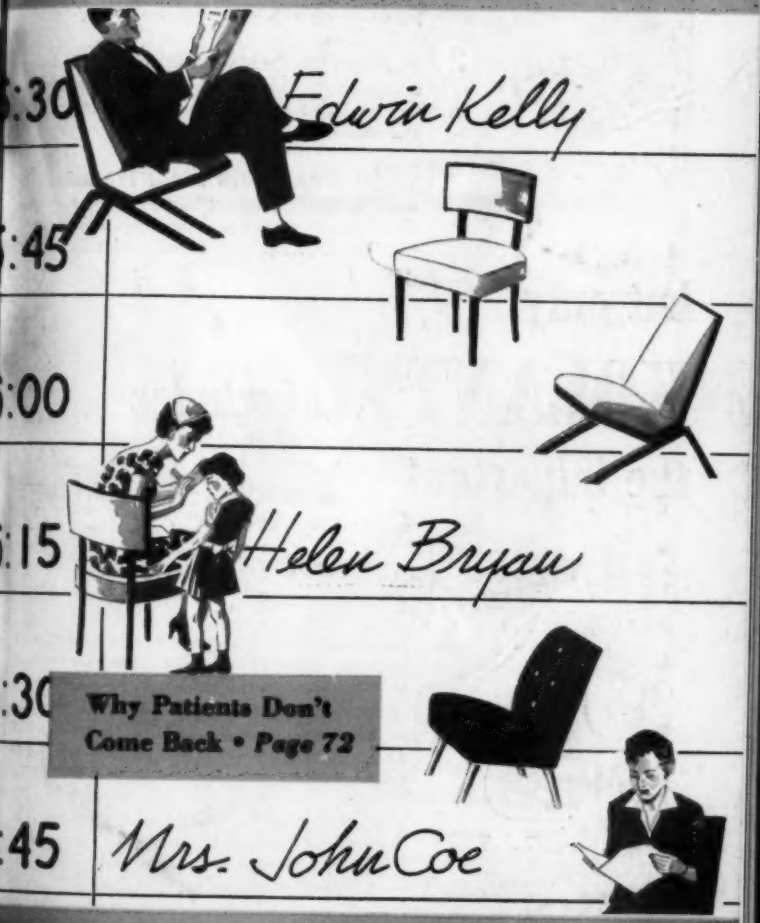
August **Medical Economics**



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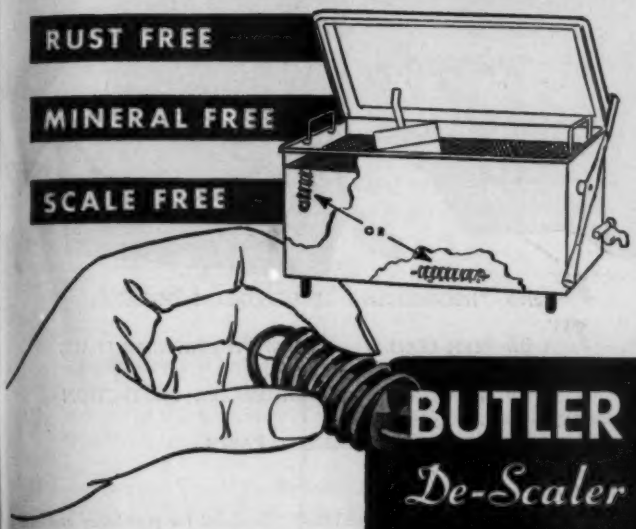

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Medical Economics

• • • *August 1952* • • •

[CONTINUED ON FOLLOWING PAGE]

Contents [*Continued*]

DEPARTMENTS

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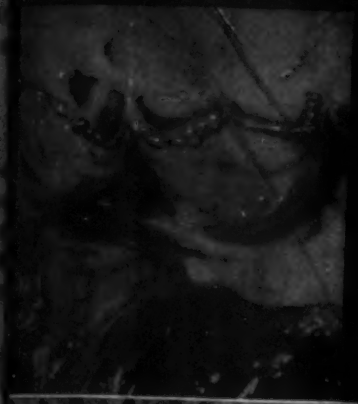
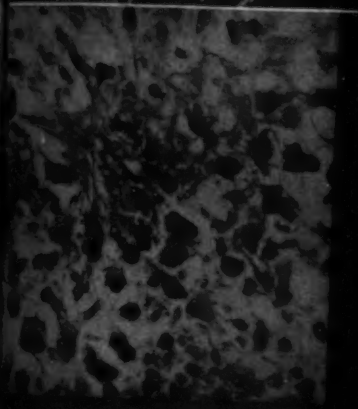
response in rheumatic fever



q. Does cortisone influence the [illegible] lesions of rheumatic fever?

a. Early cortisone administration suppresses and in some cases may even prevent serious cardiac damage.



q. What effect does cortisone have on acute rheumatic fever?

a. Often within 24 hours after cortisone therapy, the severely ill, toxic patient appears alert and comfortable, and within one to four days, temperature drops to normal, appetite increases, and polyarthritis subsides.

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work

worry

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For safe, double-spasmolysis

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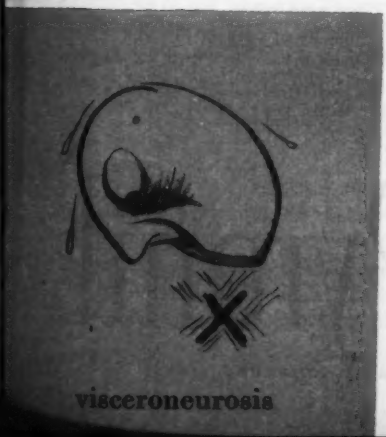
with **PHENOBARBITAL** . . . **15 mg.**
When synergistic sedation is desired

Dosage—ADULTS: 2 capsules or 2 teaspoonfuls syrup 3 times daily, before or after meals. If necessary, repeat dose at bedtime. IN INFANT COLIC: ½ to 1 teaspoonful syrup 3 times daily before feeding.[4]



Merrell
1828

New York • CINCINNATI • Toronto

1. Hock, C. W.: J. Med. Assn. Ga. 40:22, 1951 • 2. Hufford, A. R.: J. Mich. St. Med. Soc. 49:1308, 1950 • 3. Chamberlin, D. T.: Gastroenterology 17:224, 1951 • 4. Pakula, S. F.: Postgrad. Med. 11:123, 1952—*Trade-mark "Bentyl" Hydrochloride*

CLINICIANS SAY...

"Best yet for control of hay-fever symptoms."

A majority of investigating clinicians preferred 'Co-Pyronil' (Pyrrobutamine Compound, Lilly) to any other antihistaminic. This record was achieved during the 1951 season, when ragweed pollen counts soared to their highest point in the antihistamine era. Four outstanding advantages—quicker onset, better control of symptoms, longer-lasting relief, and fewer side-effects—were repeatedly noted. Also, patients liked the convenience of fewer doses—usually only one or two capsules morning and night.

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PULVULES

'Co-Pyronil'

(PYRROBUTAMINE COMPOUND, LILLY)

Panorama

Diathermy deadline extended: The Federal Communications Commission has granted physicians an extra year to replace their old-style diathermy units with equipment that meets new F.C.C. specifications. They now have until June 30, 1953 . . . Determined to suppress "ghost surgery," the New York State medical society now denies malpractice insurance in its group policy to any M.D. who, it finds, "employs or accepts employment as" a ghost surgeon . . . Do ordinary prepay plans take account of catastrophic hospital bills? Definitely yes, reports Michigan's Blue Cross plan, which last year paid one bill of over $1,000 for every eighty minutes of every workday. Many of these bills, it adds, ran up to three or four thousand dollars apiece.

New star on the horizon: To help the public distinguish G.P.'s from other physicians listed in classified telephone directories, an A.M.A. committee has proposed that G.P. names be marked with an asterisk . . . An article called "Your Druggist Can Kill You," in a recent issue of Focus magazine, stirred up such a hornets' nest that the publisher recalled newsstand copies and publicly apologized, according to President Don E. Francke of the American Pharmaceutical Association . . . Election-year note: After finding that fifty Toledo, Ohio, physicians weren't registered to vote in 1950, the local medical society went after them by letter. The result: 95 per cent of its membership of over 400 doctors are now registered.

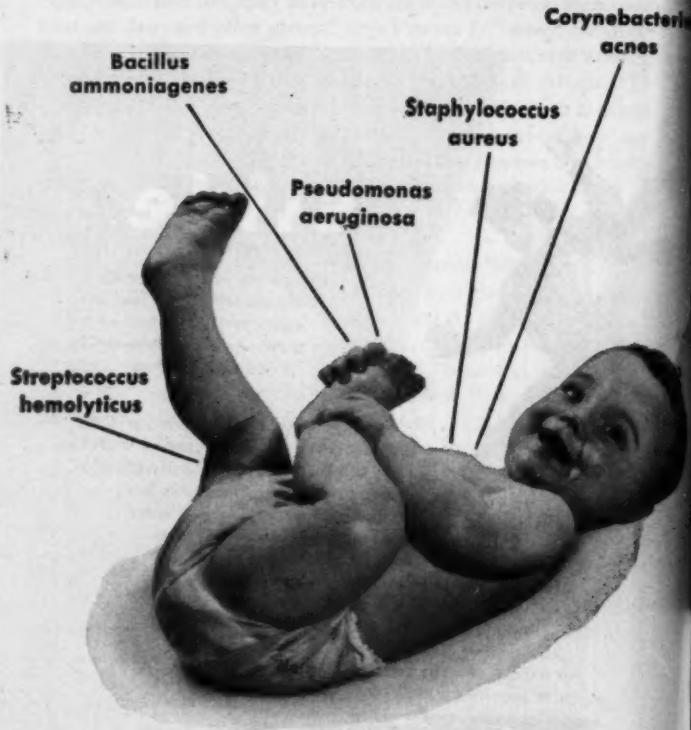
Doctors don't *always* fight the Government. Example: In Maryland, the state medical society has announced its full support of the board of medical examiners "in taking the licenses away from physicians convicted of income tax evasion" . . . Are dentists more unselfish than physicians? By promoting fluoridation of water, school teeth-care programs, and research to

curb dental diseases, they have done more "to decrease their own business than any other group," says Francis J. Garvey, an attorney for the American Dental Association . . . Five national nursing organizations are being combined into two catch-all groups: (1) a revised old one (the American Nurses' Association), to look out for the nurses' professional interests; and (2) a brand new one (the National League for Nursing), made up of nurses and others who aim to improve organized nursing services and education.

Winner take all? In their "friendly race" for a cancer cure, osteopaths "may win out" over the medical profession, predicts Detroit Osteopath Raymond A. Biggs . . . Doctors won't be fully available for emergency calls until they begin to get hungry, declares an unidentified but "wise and disillusioned physician" quoted approvingly by President F. E. Luger of the Saginaw County (Mich.) Medical Society . . . Since medical students need a better grasp of economics, the University of Colorado medical school now allots 5 to 10 per cent of its curriculum to such "non-technical" training, according to the university's bulletin.

The world's oldest profession is psychiatry, not prostitution, says Yale Anthropologist George Peter Murdock. His argument: Primitive peoples lack prostitutes but abound with "medicine men" who specialize in curing mental diseases . . . By charging patients cost, plus 10 per cent, for all ordinary services, St. Luke's Hospital, Cleveland, Ohio, claims to have taken "the guesswork out of rate-making"; also, say the hospital's trustees, their unique billing scheme prevents paying patients from being "soaked" to make up deficits.

Forced rural placement of Russia's female M.D.'s has hit a snag because their laymen husbands won't follow them to the sticks, Izvestia reveals. The Government newspaper warns reluctant spouses that they'd better give in, or else . . . The vanishing color line: Already in the highest post ever held by a Negro physician in any county medical association, Dr. Peter M. Murray, new vice president of the New York County society, is in line for the job as president-elect next year.



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If you have not already done so, why not try Johnson's Baby Lotion? You will find this protective, soothing, pleasantly fragrant lotion a very helpful agent in the prophylaxis and treatment of *miliaria*, *excoriated buttocks*, *diaper rash*, *impetigo*, and *cradle cap*.

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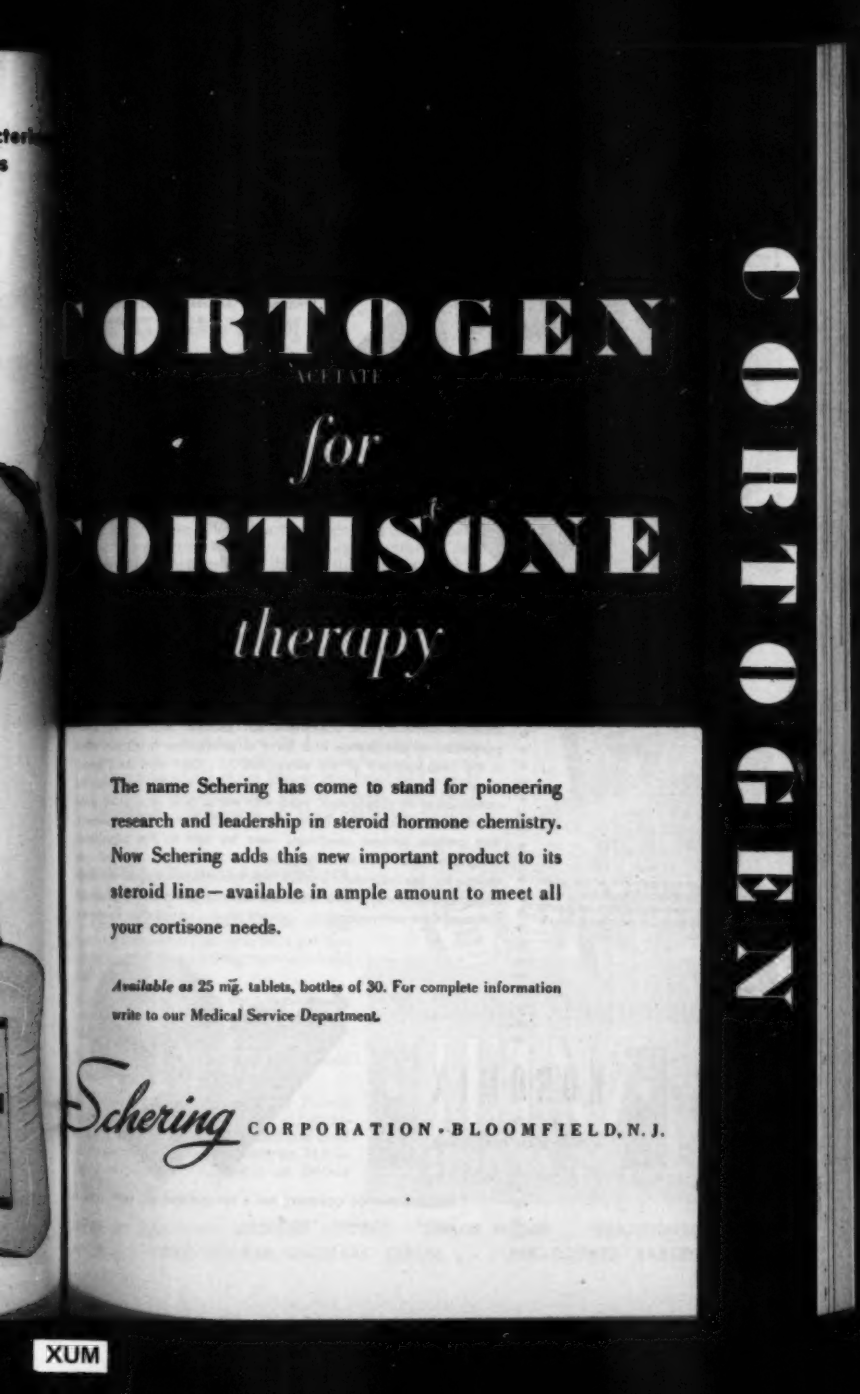
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—THEAETETUS, SEC. 155

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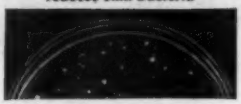
Photomicros show how Dial reduces Skin Bacteria



With ordinary soap, the most thorough washing leaves thousands of bacteria on the skin.

With Dial, with Hexachlorophene, daily use removes up to 95% of skin bacteria.

1. *Reduces chance of infection* following abrasions, scratches, for Dial effectively reduces skin bacteria count.

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AN **A**NTACID WITH PROMPT

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RECOGNI**Z**ING THE NEED FOR

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5 cc.; bottles of 8 fl.oz.

For extra sedation and spasmolysis:

Tablets **ALZINOX** with Phenobarb
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E. L. PATCH COMPANY

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Speaking Frankly

More Loopholes

SIRS: I have read your editorial on "Blue Shield Loopholes" [June, 1952] with interest; but it seems to me that it neglects three important points:

1. Insurance for comprehensive care *is* practicable, as demonstrated by the Health Insurance Plan of Greater New York, the Permanente Foundation, and the Windsor (Ont.) medical society's fee-for-service plan.

2. Your editorial fails to mention two unfortunate effects of limiting insurance to hospitalized illness: (a) with minor services and health examinations excluded, subscribers are not encouraged to seek early diagnosis and treatment; and (b) the doctor and patient may both be tempted to use the hospital more frequently than necessary. In my opinion, much would be gained by including at least diagnostic services outside the hospital and visiting-nurse services at home, on a fee-for-service basis.

3. Another "loophole" in Blue Shield: Subscribers whose incomes are above the service limit are often required to pay an additional amount to their doctors. Many a physician now takes advantage of this provision by upping his fee when he learns that the patient has Blue Shield coverage.

Dean A. Clark, M.D.
Boston, Mass.

Fee Splitting

SIRS: The first of your fee splitting articles is, to say the least, provocative. I've had a hard time distinguishing the writer's *facts* from his *opinions*, though. He seems, for instance, to consider it a fact that the referring physician is not a qualified surgical assistant or anesthetist. What a mistake we're making, then, by permitting the "unqualified" M.D. to assist during his interne and resident years!

I also question another of the author's statements: "Like other prices in a free economy, medical fees are established essentially by the law of supply and demand. In the operating room, as in Hollywood and elsewhere, emotion rather than logic may determine demand—and hence price."

Even if other prices *were* determined by the law of supply and demand, medical fees cannot be. If they were, the rural G.P. who furnishes the only supply for a great demand should charge the highest fees of all. As to "emotion rather

than logic" determining price, I would hate to feel that any segment of our profession takes unfair advantage of a patient or his family in time of stress.

Albert S. Dix, M.D.
Mobile, Ala.

SIRS: A few points that were overlooked in Robert Cunningham's first article should in all fairness be mentioned.

First, he says the American College of Surgeons considers it a subterfuge for the referring physician to act as assistant in an operation. Is this necessarily so, when such an M.D. may have assisted in literally hundreds of operations—even though he's not one of "the anointed"?

Secondly, the author states that a surgeon is entitled to the entire high fee because he shoulders the blame when anything goes wrong. As a busy general practitioner, I can say that this is simply not so. The referring physician must face the patient's family after the operation; in all likelihood, the surgeon will never see them again.

In my opinion, present surgical practices are actually "in restraint of trade." In other words, many a G.P. is forced to refer cases that he is fully capable of handling, simply because the hospital will not permit him to perform any procedure requiring an anesthetic.

In the light of these facts, is it wrong for a G.P. to expect something for his time and trouble? No one has yet been able to expose the so-called evil in fee splitting—possibly because there is none.

Robert R. Grimes, M.D.
Teaneck, N.J.

SIRS: Your fee splitting article criticizes physicians for actions that seem to be considered ethical by Blue Shield. In my state, the plan pays $75 for an appendectomy. The referring doctor gets $22 for assisting and aftercare; the surgeon gets the rest. And the surgeon alone submits the joint bill to Blue Shield.

Is this, or is this not, "fee splitting"?

M.D., Massachusetts

SIRS: The first article makes very interesting reading, but to my mind it misses the boat completely. For some reason, all the people like Mr. Cunningham who write about current medical evils—and God knows they are manifold!—seem incredibly naive.

The author touches on the answer to the problem, but fails to develop it, when he says, "The essence of capitalism is that goods and services should compete freely with one another in the open market."

Does such a condition exist in medicine as it is set up at present?

The pious hypocrites who yell loudest and longest against fee splitting are usually the ones who stand to pocket all the fee. These are the same men who do their damnedest to see that everyone but themselves is limited to making house calls between 1 A.M. and 6 A.M. [MORE→

Surely anyone with an ear open to the wail of most doctors knows they are fully capable of handling an overwhelming percentage of the hospital work that they are now compelled to refer. Why don't we eliminate this serfdom of the general practitioner to the specialist and *really* return to the free competition of capitalism?

Make it possible for every physician in the community to have hospital affiliations and staff status, and you will eliminate fee splitting. At present, the best the average physician can do is find the work, bring it to the specialist, and then get his cut—or get a new specialist!

William Jacobs, M.D.
Irvington, N.J.

SIRS: I congratulate you. Mr. Cunningham's articles are timely. They needed to be written. They have a worth-while message.

This discussion of a provocative and prevalent problem is, without question, the most searching, the most honest, and one of the ablest that have ever been presented. As such, it merits serious study (with action, as indicated) on the part of every practicing physician. Moreover, the training of every medical student should include lectures on the facts and principles of ethics set forth in the series.

John W. Sherrick, M.D.
Oakland, Calif.

SIRS: I read Mr. Cunningham's initial article on fee splitting with some irritation and a great deal of amusement. He obviously knows very little about medicine, the patient's welfare, and relationships between doctors. Among M.D.'s as a whole, no one is worried about the non-existent "problem of fee splitting" except the organized surgeons, whose only worry is how to get for themselves all the money a patient is willing to pay. Mr. Cunningham appears to have obtained most of his information from this group.

I should like to point out to him that the best type of medical care comes when the patient places himself in the hands of a capable and broadly experienced doctor who will do what is necessary in the home or office, if possible, to cut expenses. If the family doctor feels that the job can be done better by someone else, he will call him in as a consultant; but he will *retain his control of the case.*

If an operation is necessary, the *family doctor should be present,* if only as an observer, to prevent unnecessary surgery and lapses in technique and judgment. The G.P. should also retain control of the preoperative and postoperative care, to prevent lapses such as the surgeon's forgetting to see a newly referred patient or prescribing a drug to which the patient is sensitive.

Having established these points, let us look at the five arrangements called fee splitting by the Cole committee, as cited in your article:

No one can argue with three of these. If the surgeon sends part of

94 out of 102 patients with hay fever benefited by PHENERGAN therapy *

Most efficacious

Longest-Acting

New clinical evidence continues to emphasize the superiority of Phenergan in the treatment of hay fever:

"Results obtained with Phenergan in symptomatic relief of pollen hay fever were far superior to those obtained with any other antihistaminic agent."*

"No other antihistamine, in our experience, has exhibited such prolonged action."*

SYRUP **TABLETS**

PHENERGAN

Hydrochloride

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(N-[2'-dimethylamino-2'-methyl] ethyl phenothiazine hydrochloride) Wyeth

Wyeth®

*Silbert, N. E.: Ann. Allergy *10*:2, May-June 1952

SUPPLIED: Syrup Phenergan Hydrochloride, 6.25 mg. per 5 cc., bottles of 1 pt. Tablets Phenergan Hydrochloride, 12.5 mg. each, bottles of 100 tablets. ALSO AVAILABLE: *2 dosage forms for topical therapy*—Cream Phenergan Hydrochloride, tubes of 1.12 ounces; Phenergan Lotion with Neocalamine, bottles of 4 fluid-ounces; *For control of "allergic" cough associated with vasomotor rhinitis, pollen hay fever*—Phenergan Expectorant with Codeine, bottles of 1 pint.

the fee to the referring physician, if a group pays the referring physician, or if an appliance dealer offers rebates, this may justifiably be considered fee splitting; and the author has a right to condemn such practices.

When the family doctor assists or gives the anesthetic, however, this is *not* fee splitting; it is the only correct way to do things. I have pointed out that the family doctor should be present during an operation. There is no reason why a highly trained man should stand and observe while a stranger gives the anesthetic. For the services rendered, the family doctor should collect his bill at the usual rates.

Nor is it fee splitting when the family doctor collects the money and sends the surgeon's fee to him. This is a highly commendable practice that makes it easy for the patient to pay his bill.

Robert J. Greaves, M.D.
Collinsville, Ill.

Says Mr. Cunningham: "In connection with the first paragraph of Dr. Greaves' letter, it seems to me he has overlooked the fact that voluntary associations of physicians, like the American Medical Association and the American College of Surgeons, have made the regulations on fee splitting. I simply report them."

Industrial Practice

SIRS: According to an item in the April Newsvane, a higher-bracket industrial-practice specialist "must be, first of all, a good, all-around surgeon."

At the risk of seeming peevish, I insist that this concept is inaccurate and outmoded.

The day has long since gone by when the primary qualification for an industrial physician, high or low bracket, is proficiency in surgery. In some industries, surgical problems constitute an important—if fractional—part of the over-all medical program; but modern industrial medicine is first and foremost *preventive* in approach and *medical* in nature.

Ronald F. Buchan, M.D.
Director of Employe Health
Prudential Insurance Company
Newark, N.J.

Stuffed Shirts

SIRS: My wife and I have both enjoyed your excellent articles, "I'm a Doctor's Wife Again" and "I Streamlined My Practice—Alas!" Please keep reminding us all *not* to turn into chrome-plated stuffed shirts.

M.D., Kansas

What's Free?

SIRS: A recent issue of MEDICAL ECONOMICS features a cartoon that is inaccurate, misleading, and unjust, since it indicates that 2 million Government workers get free medical care.

During my thirty-nine years with the U.S. Railway Mail Service, I have had to pay for having my tonsils, appendix, and one lobe of a lung removed; I have also footed

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The acute diarrheal disturbances seen so frequently in adults, infants and children during the warm months are promptly controlled by Arobon.

Made of specially prepared carob flour, Arobon produces its excellent results because of its high natural content of pectin and lignin. These substances are demulcent and soothing, and they adsorb offending bacteria and toxins. Controlled clinical studies[1, 2, 3] have shown that Arobon leads to thickening of the stools in 24 hours and to formed stools in 48 hours in most patients.

It may be used as the sole medication in non-specific diarrheas. In the more severe dysenteries, it is a valuable adjuvant. Arobon is easily prepared for adults and children by simply mixing it with milk, and for infants by mixing it with skim milk or water and boiling for ½ minute.

1. Smith, A. E., and Fischer, C. C.: J. Pediat. *35*:422 (Oct.) 1949.
2. Kaliski, S. R., and Mitchell, D. D.: Texas State J. Med. *46*:675 (Sept.) 1950.
3. Plowright, T. R.: J. Pediat. *39*:16 (July) 1951.

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this preparation is indicated in:

Pneumonia	Acute sinusitis
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this preparation has important advantages:

1. Increased antibacterial spectrum.
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'Eskacillin 100-Sulfas' is so pleasant-tasting that children enjoy taking whatever amount you prescribe. You will find this fluid penicillin-sulfonamide combination a logical preparation to use in treating many of the common bacterial infections of childhood.

Formula: Each teaspoonful (5 cc.) supplies: crystalline potassium penicillin G, 100,000 Units; sulfadiazine, 0.167 Gm.; sulfamerazine, 0.167 Gm.; sulfamethazine, 0.167 Gm.

Available: On prescription only, in 2 fl. oz. bottles.

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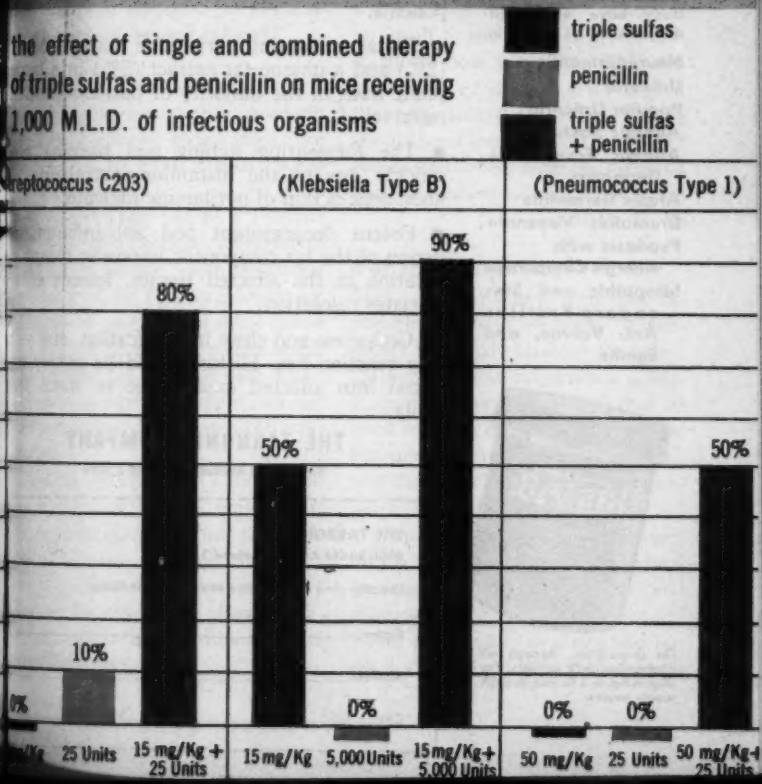

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MH

the bill for pneumonia and a prolonged siege of malaria. What's this about "free" medical care for us civil employes?

John H. Priestley
Memphis, Tenn.

According to Elmer B. Staats, Assistant Director of the Bureau of the Budget, Federal employes are eligible to receive Government care "in the event of injury or illness in the line of duty." The drawing in question was accompanied by an explanatory note that said, in part: "Federal medicine is currently available in some measure [to Government workers, among others]."

Verdant Pocketbooks

SIRS: During a sojourn in southern Florida, I noticed this slogan on state auto license plates: "Keep Florida Green."

It wasn't long before I realized that they were probably referring to that "green lettuce" with the dollar sign on it. Take Florida doctors, for example. A neighbor of mine called in a local M.D. to treat a case of flu. The charge for a house call: $20—and no hypos given! A night call cost another visitor $30, penicillin included.

It seems to me that it's about time the doctors of Florida realize that this overcharging can hurt the medical profession all over the U.S. Florida is almost a year-round resort now, so the old excuse about "making hay while the sun shines" is less valid than ever.

What about medicine's public relations? Have the Floridians never heard of it? Personally, I'm disgusted!

M.D., Ohio

Rank Treatment?

SIRS: In a recent issue of a popular magazine, I saw a photograph of an Army field hospital in Korea. It showed a physician who was a lieutenant and a nurse who was a captain. In the caption beneath the picture, the doctor was barely mentioned, while the nurse was given five lines of print.

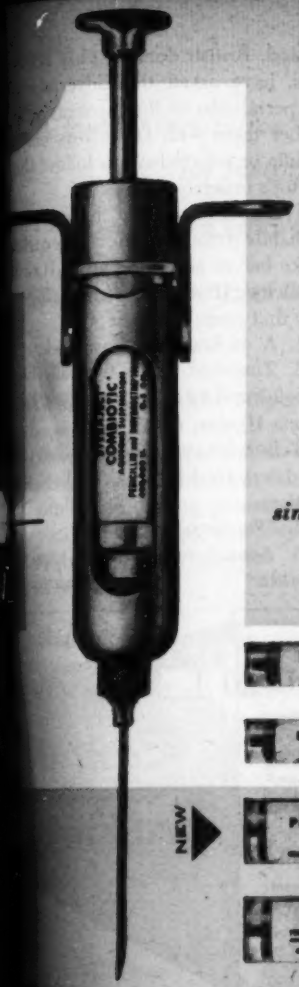
I feel that this kind of picture is an insult to the medical profession. It shows how very, very little the armed forces value the services of their physicians. Certainly, there should be at least two full grades between the lowest ranking physician and the highest ranking nurse.

M.D., Texas

For the Neophytes

SIRS: I was pleased with your favorable review of my book, "Investments for Professional People" [March MEDICAL ECONOMICS, p. 50]. I agree with you, of course, that no book can be a satisfactory substitute for personal investment guidance, and this book is not intended to replace it.

However, as you are well aware, only a small fraction of the medical profession avails itself of personal guidance. Even those who do are better prepared to evaluate and apply such advice if they know how to



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***one* sterile needle**
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Plunger and cartridge connect... you can *aspirate* before injecting!

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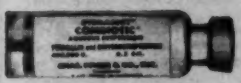

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Steraject Dihydrostreptomycin Sulfate Solution (1 gram)

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analyze some of their own investment problems.

My book is purposely concise to accommodate the requirements of the busy professional person who might be frightened away by a larger, more comprehensive volume. That you can well appreciate this requirement is attested by the careful selection of pithy articles in your magazine.

Best wishes for continued success in your attempts to educate us investing neophytes.

Robert U. Cooper, M.D.
Washington, D.C.

Who's Afraid?

SIRS: Are you afraid of socialized medicine? No need to be—if a recent news story from London is to be trusted. British doctors, this item says, have asked the Government for permission to fine patients who bother them with frivolous complaints or who refuse to follow the doctor's orders.

This prompts me to think of the demands American doctors could make before accepting socialized medicine. Here, for example, are a few that come to mind:

1. A 40-hour, five-day week.
2. Time-and-a-half for calls between 5 and 10 P.M.; triple-time between 10 P.M. and 8 A.M.
3. Regular cost-of-living raises (to be determined by local medical societies).
4. "Portal-to-portal" pay.
5. Annual winter health trips to Florida. [MORE—

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When you prescribe Nupercainal you provide much more than a mere cosmetic coating for sunburn. Nupercainal contains dibucaine, highly potent, non-narcotic anesthetic, affording hours of relief from pain and itching.

Nupercainal Ointment contains 1% dibucaine in a lanolin-petrolatum base. Supplied in tubes of one ounce; jars of one pound.

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6. Free "tools of the trade" (including a serviceable car, such as a Cadillac).

7. "Voluntary" contributions to our welfare fund from each patient at the time of treatment.

As for fines, we might insist that payments be made to our general retirement fund for the following:

Eating garlic prior to an examination; giving the wrong address for a house call; breaking a leg on a holiday; calling a doctor away from any form of entertainment; canceling appointments; having a baby between 5 P.M. and 8 A.M.; appendicitis (the fine here is automatic, since the appendix should have been removed electively).

P.S. to my patients: I'm happy treating you as things now stand. Let's hope that my tongue-in-cheek suggestions don't become a part of our relationship—*ever*.

W. A. Waters, M.D.
Cushing, Okla.

Pity the Doctor

SIRS: I submit this personal experience as an example of how enviable the physician's lot must seem to the "underprivileged."

On a wet evening not long ago, I was lugging my black bag across Michigan Avenue, near Detroit's Skid Row, and I must have looked as weary and bedraggled as I felt after a long, hard day. A bum who was watching me remarked, "It's a tough way to make a living, Doctor."

Maybe he's right.

M.D., Michigan

7½ gr.

7½ gr. (0.5 Gm.) *BLUE* CAPSULES CHLORAL HYDRATE—*Fellows*

• DESIRABLE SLEEP lasting from five to eight hours, usually free from undesirable after-effects. Pulse and respiration are slowed in the same manner as in normal sleep. Reflexes are not abolished and the patient can be readily aroused.[2] "CHLORAL HYDRATE produces a normal type of sleep, and is rarely followed by 'hangover'."[1]

Dosage: One to two 7½ gr., or two to four 3¾ gr. capsules at bedtime.

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• MITIME SEDATION for the patient who needs daytime sedation and relaxation with complete comfort.

Dosage: One 3¾ gr. capsule three times a day, after meals.

3¾ gr.

CRETION—Rapid and complete, therefore no depressant after-effects.[3, 4]

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3¾ gr. (0.25 Gm.) Blue and white capsules. . . bottles of 24's and 100's
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NEW safeguard for the "drowning heart." Prescribe in congestive heart failure, recurring edema, cardiac asthma, hypertensive heart disease, dyspnea of cardiac origin, arteriosclerotic heart disease, fluid retention masked by obesity and for patients averse to their low-sodium diets.

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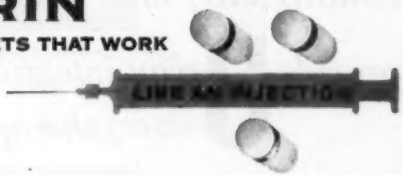
THE DIURETIC TABLETS THAT WORK



NEW convenience, simplicity and safety. Replaces dependence on injections, xanthines, ammonium chloride, resins, aminophylline and other less effective tablets.

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a product of *Lakeside leadership in diuretic research*

How To Use This New Drug: Maintenance of the edema-free state has been accomplished with as little as one NEOHYDRIN Tablet a day. Often this dosage of NEOHYDRIN will obtain in a week an effect comparable to a weekly injection of MERCUHYDRIN®. When more intensive therapy is required one tablet or more three times daily may be prescribed as determined by the physician.

Gradual attainment of the ultimate maintenance dosage is recommended to preclude gastrointestinal upset which may occur in occasional patients with immediate high dosage. Although sustained, the onset of NEOHYDRIN diuresis is gradual. Injections of MERCUHYDRIN will be initially necessary in acute severe decompensation.

Any patient receiving a diuretic should ingest daily a glass of orange juice or other supplementary source of potassium.

Packaging:

NEOHYDRIN: Bottles of 50 tablets. There are 18.3 mg. of chloromercuri-2-methoxy-propylurea in each tablet.

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...helps ensure optimum nutrition
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...improves nutritive intake
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SUPPLIED: In 1- and 5-pound cans, plain or chocolate flavor; available at all leading pharmacies. The 1-pound can retails at $1.55 and lasts for eight days on a 1000-calorie diet.

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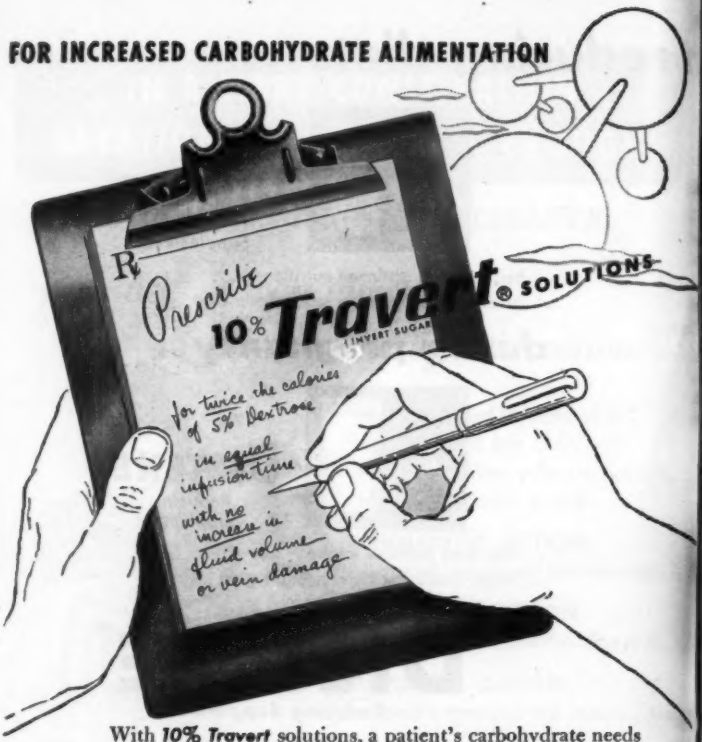

With ***10% Travert*** solutions, a patient's carbohydrate needs can be more nearly satisfied within a reasonable time with no increase in fluid volume or vein damage.

Travert solutions are sterile, crystal-clear, colorless, non-pyrogenic and non-antigenic. They are prepared by the hydrolysis of cane sugar and are composed of equal parts of D-glucose (dextrose) and D-fructose (levulose). ***Travert*** solutions are available in water or saline in 150 cc., 500 cc., 1000 cc. sizes. For the treatment of potassium deficiency, ***10% Travert*** solutions with 0.3% potassium chloride are also available in 1000 cc. containers.

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"therapeutic bile" overcomes stasis

what is "therapeutic bile"?

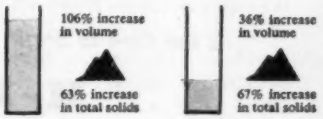
Thin, free-flowing bile in copious amounts as produced by *hydro*choleresis with *Decholin*.

what does "therapeutic bile" do?

Overcomes stasis in chronic cholecystitis and noncalculous cholangitis by flushing thickened bile, mucus plugs and debris from the biliary tract.

how does "therapeutic bile" differ from other bile?

"THERAPEUTIC BILE" is higher in fluid content and lower in solid content than bile produced by choleretics, e.g., ox bile salts.



Hydro*choleretic: *Decholin

Choleretic: Ox bile salts

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how is "therapeutic bile" obtained?

"THERAPEUTIC BILE" is obtained by adequate dosage of *Decholin* and *Decholin Sodium*. Most patients require one or two tablets t.i.d. for four to six weeks. Prescription of 100 tablets is recommended for maximum efficacy and economy. More prompt and intensive *hydro*choleresis may be achieved by initiating therapy with *Decholin Sodium* 5 cc. to 10 cc. intravenously, once daily.

Decholin Tablets, 3¾ gr. (0.25 Gm.), bottles of 100, 500, 1000 and 5000.

Decholin Sodium (brand of sodium dehydrocholate) 20% aqueous solution, ampuls of 3 cc., 5 cc. and 10 cc.

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Premenstrual Tension...Dysmenorrhe

M-MINUS 4 is the rational pharmacologic approach[1,2] and the clinically effective treatment[2,3,4] for relief of breast tenderness, abdominal distention, headache, cramps, psychic upsets and general malaise preceding and accompanying menstruation.

M-MINUS 4—an agent for the effective control of premenstrual tension and dysmenorrhea—

- . . . blocks the accumulation of excess tissue fluids responsible for most of the symptoms
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Each tablet contains: N,N-Dimethyl-N'-(2-pyridyl)-N'-(p-methoxybenzyl) ethylenediamine 8-bromtheophyllinate [pyrabrom] 50 mg., and acetophenetidin 100 mg.

1. Robinson, F. H., Jr., and Farr, L. E., Ann. Int. Med., 14:8 (1940)
2. Bickers, W. and Woods, M., Texas Rep. Biol. Med., 9:8 (1951)
3. Vainder, M., Indust. Med. & Surg., 20:199 (1951)
4. Bickers, W. and Woods, M., New England J. Med., 245:62 (1951)

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Sidelights

Professional Courtesy

More and more complaints are being heard, says Lawyer-Physician Louis J. Regan, from doctors who have unexpectedly received a doctor's bill. The question these men are asking is, "Whatever happened to professional courtesy?"

We've been getting this query, too. One such complaint stemmed from a doctor who had Blue Shield coverage for his family. Another came from a doctor in full-time industrial work. A third complaint originated with an M.D. whose daughter had been making regular visits to a psychiatrist. In all three cases, the physicians had been billed for their colleague's services—and weren't sure they should have been.

Prodded by Dr. Regan and others, the A.M.A. Judicial Council has shed some much-needed light on such cases. To wit:

¶ If services to a colleague (or his dependents) are covered by insurance, then the doctor rendering the services "may accept the insurance benefits without violating . . . the Principles of Medical Ethics."

¶ Even though a doctor is not in private practice, he is still entitled to medical services given "cheerfully and without recompense" by his local colleagues.

¶ Psychiatrists, like all other doctors, "may not ethically charge a professional fee for services rendered to a colleague's dependents in the local community."

None of this prevents reimbursement for travel costs, out-of-pocket expenses, etc. And if unusually time-consuming services are involved, the doctor who benefits "should desire, in some way, to compensate the physician rendering such unusual services." But with the exceptions noted, the Judicial Council reaffirms the fact that free service to colleagues is still a must for *every* ethical physician.

Practice Management

We're often asked to recommend consultants in professional management or group practice. "Please send me the names of a couple of reliable authorities in these fields," some doctor may write, "preferably located within 50 miles of my office."

Actually, there are mighty few such consultants around. Our own list of well-qualified men, for example, includes fewer than two dozen professional management authorities, fewer than one dozen group practice consultants. And that's for the whole country. So the average doctor is probably lucky if there's

such a person within 500 miles.

This scarcity means that m M.D.'s must work out their o management techniques. Not c pletely unaided, of course; the help to be had from this magaz from accountants and lawyers, p sibly from other local sources. the biggest help of all—and this plies whether you have expert co sel or not—is a cultivated zest for ing things efficiently.

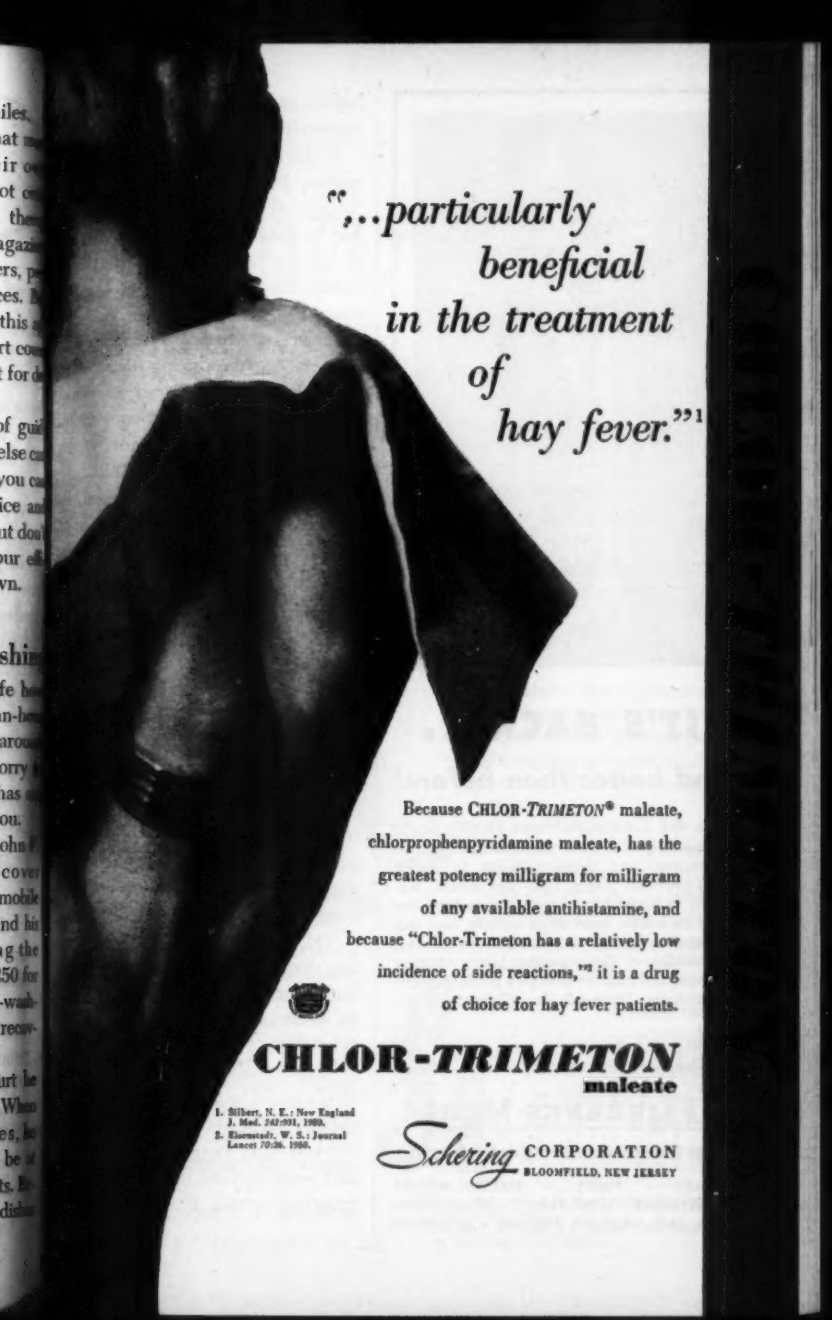
In other words, the best of gui ance goes just so far. No one else c run your practice as well as you c yourself. So get all the advice a assistance that's available—but don forget also to sharpen up your ef ciency techniques on your own.

Doctors and Dish-Washi

Have you ever told your wife h lucky she was to have a $10-an-ho man doing odd jobs for free arou the house? If so, you'll be sorry hear that a Michigan court has the ground out from under you.

A psychologist named John Franklin was seeking to recover damages following an automobile accident in which both he and his wife were involved. Among the "damages" he sought was $250 for the twenty-five hours of dish-washing he'd put in while his wife recovered from her injuries.

Dr. Franklin told the court he was "fighting for a principle." When a psychologist washes dishes, he reasoned, payment ought to be at the going rate for psychologists. Besides, he had never washed dishes


"...particularly beneficial in the treatment of hay fever."[1]
Because CHLOR-TRIMETON® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.
CHLOR-TRIMETON
maleate
1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:38, 1950.
Schering CORPORATION
BLOOMFIELD, NEW JERSEY

before and found that he disliked intensely.

Unfortunately for doctors everywhere, Judge David C. Vokes saw things otherwise. "If Dr. Frank has as great a dislike for household chores as he expressed," the court ruled, "he should have at least endeavored to secure the services of a maid or a domestic to perform these services for him during his wife's incapacity . . . The court, therefore has computed his damages in this regard at $1 per hour for twenty-five hours, or a total of $25."

That seems to settle it, men. Regardless of what you're worth in the office or hospital, you're just dollars-an-hour help around home.

What They Don't Know

Stories about people with extra heavy medical bills are often regarded as the most potent of all arguments for Federal medicine. One such story, in a recent issue of the American Federation of Labor News-Reporter, begins with these confident words: "Mr. and Mrs. Bishop of Milwaukee know why national health insurance is needed..."

Yet, interestingly enough, before the story has run its course, the labor paper has succeeded in blowing its own argument to bits. Watch closely:

"Mrs. Bishop and her husband own a small business in Milwaukee," the A.F.L. paper relates. "They both worked long hours in the business and were paying off the debts they incurred setting it up. On Sept. 1,

Mrs. Bishop was struck by a hit-and-run driver. She suffered a broken pelvis, a ruptured bladder, crushed right leg, concussion, and internal injuries. She will probably be crippled the rest of her life. The medical and hospital bills have already reached $5,000. Her hospital insurance, which covered only part of the cost, lasted only sixty days . . .

"If Congress would set up a national health insurance program," the labor paper concludes, "people like Mr. and Mrs. Bishop would not be ruined when they meet with an accident."

Now this, to our mind, is a most revealing conclusion. Here are the two main things it reveals:

1. The supporters of national health insurance don't always know what they're supporting. "Her hospital insurance . . . lasted only sixty days," laments the labor paper. Yet under national health insurance, as blueprinted in a long succession of Murray-Dingell bills, the hospital benefits would be limited to—you guessed it!—sixty days a year.

2. The supporters of private health insurance haven't made the most of what they're supporting. Where catastrophic coverage is concerned, they have actually outstripped the legislative planners. Nearly a dozen commercial carriers now offer policies that pay a major share of *all* sickness bills—with no time limits—in amounts as high as $5,000. If people like the Bishops haven't heard about this, our profession must accept at least part of the blame.

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activated oral B_{12}

in high potency

Crystamin Forté
CAPSULES

Each Crystamin Forté capsule contains:

*Crystamin	100 mcg.
Desiccated Duodenum	75 mg.
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References: Meulengracht, E.: Acta. med. Scandinav. 85:79, 1935; (2) Bethell, F. H., et al.: Univ. Hosp. Bull., Ann Arbor 15:49, 1949; (3) Hall, B. E.: Brit. Med. J. 2:585, 1950; (4) Bethell, F. H., et al.: Ann. Int. Med. 35:518, 1951.

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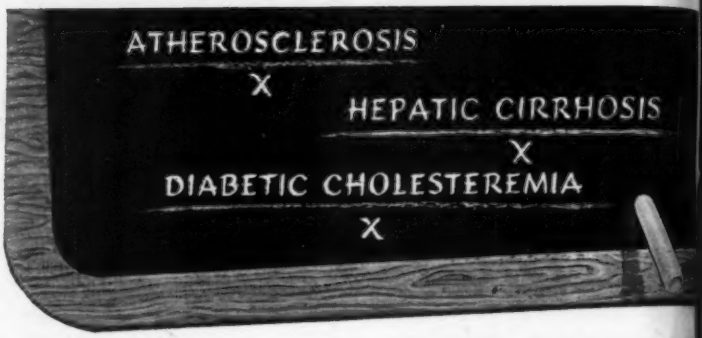

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1. Weidlein, E. R., Jr.: The Biochemistry of Inositol, Bibliographic Series Bulletin, no. 6, Pittsburgh, Pa., Mellon Institute, 1951. 2. Editorial, J. A. M. A. 141:392, 1949. 3. Gertler, M. M., et al.: Circulation 2:517, 1950.

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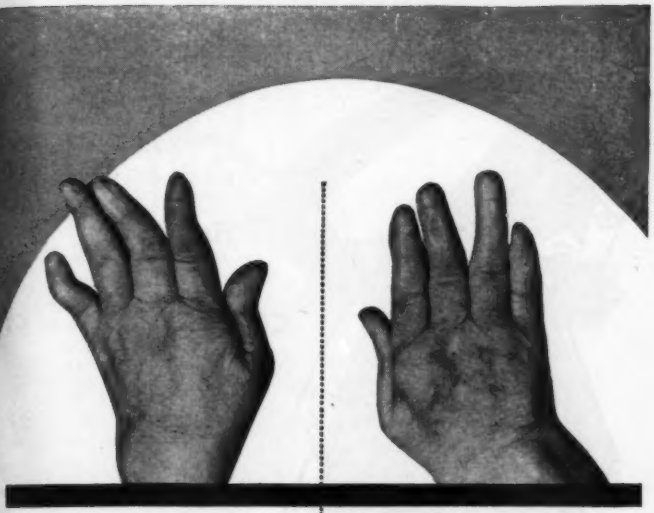

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Editorial

Take in Osteopaths?

• You could have heard a bone crack while the resolution was being read. "The House of Delegates of the American Medical Association," it said, "urges immediate action to accomplish an eventual amalgamation of the medical and osteopathic professions . . . "

No, the resolution didn't pass. But action may be forthcoming just the same. Already the American Medical Association and the American Osteopathic Association, never before on speaking terms, are conferring over the first steps that might be taken toward the proposed merger.

"We'll never endorse osteopathy as a cult," one A.M.A. officer has said, "but we may very well endorse osteopaths as being ripe for medical assimilation."

What's behind this trend? What's its real meaning for practicing physicians? Will it produce more well-trained allies—or more low-grade competition?

Whether you view osteopaths with approval or alarm, you can distill some of the answers from the following background facts:

Nearly 12,000 osteopaths practice in the United States today, with another 2,000 in training. Limited at first to the manipulative treatment taught by Founder Andrew Taylor Still, these men have steadily broadened their professional scope. Today most states license them to practice medicine and surgery on virtually the same basis as M.D.'s.

They've won acceptance in other ways, too. They get research grants from the U.S. Public Health Service; they get V.A. checks for treating veterans with service-connected disorders; they even participate in Blue Shield plans sponsored by some medical societies.

Why this increased recognition? Mainly, because of their improved training. "The curricula of modern osteopathic schools," Dr. John Cline, recent A.M.A. president, points out, "now are patterned largely after those of schools of medicine." There has been a "progressive reduction of the emphasis upon the teaching of osteopathy, in favor of instructions in medicine and surgery." Further improvement would be hastened, Dr. Cline observes, by "removal of the stigma of cultism."

That stigma has separated medical men and osteopaths for more than fifty years. "Osteopaths are cultists," the A.M.A. Judicial Coun-

cil still holds, "and all voluntarily associated activities with cultists are unethical." This means an M.D. can't ethically teach in the osteopaths' schools, work with them in hospitals, or even consult with them privately.

Is this ban unrealistic? Is it bad for the public? Large numbers of A.M.A. members believe the answer is "Yes." They feel that:

¶ Physicians should be allowed to teach in osteopathic schools.

¶ The A.M.A. should assist in upgrading the standards of these schools.

¶ Osteopathic schools should be rated as full-fledged medical schools as soon as they're ready for it.

¶ New graduates should then automatically be taken into the medical profession.

¶ Old graduates should be given a chance to qualify for the same recognition.

This is, of course, controversial stuff. Consider M.D. reactions in the two states with the greatest number of osteopaths: California and Missouri. While California medical leaders are pushing hard for amalgamation, Missouri medical leaders want to go slow. Some objections raised by the latter may illustrate the complexity of the problem:

"Medical specialists can afford to be big-hearted about this matter," says a Missouri M.D., "because osteopaths often feed patients to them. But what about medical men in general practice? In many small towns, osteopaths are their direct competition. Any A.M.A. endorsement of the osteos is going to hurt our small-town G.P.'s.

"And what about the osteopathic schools?" this physician continues. "They're said to give almost the same courses as medical schools—but do they really? As far as I know, the Still school in Missouri has never permitted inspection by a qualified outsider. I doubt that it's anywhere near comparable to an approved medical school."

Then there's the problem of the older osteopaths, another Missourian points out: "We can't take *them* into the medical profession—not if they adhere to the Still dogmas. After all, before you can join the church, you have to renounce sin."

Yet to California physicians and others, such objections don't seem insurmountable. Competition from osteopaths may be a problem in Missouri, they concede; but only because osteopathy was born and brought up there. Elsewhere, M.D.'s are apt to outnumber D.O.'s by something like twenty to one. "If *that* much competition bothers us," says an Ohio medical leader, "then we're in pretty poor shape."

As for the quality of the osteopathic schools, it no doubt varies widely. But at least two that have been visited in the recent past by M.D.'s have been found fairly close to medicine's standards. Proponents of the amalgamation cite this as a hopeful sign.

They cite, too, the undeniable fact that older osteopaths—the Still-

trained ones—are dying off, thus gradually lessening another obstacle to the proposed merger.

What will the upshot be?

Our guess is that osteopathy *will* be absorbed into the mainstream of American medicine. It won't happen overnight; it may take ten years to complete. But if better medical care to the public is in prospect, what physician can stand in the way? —H. SHERIDAN BAKETEL, M.D.

'Blue Shield Makes Us Split Fees'

So say physicians in a good many areas. Here's what their dilemma amounts to

• An estimated 70 per cent of all surgery in this country is done in communities where internes and residents aren't available as assistants. So who provides the helping hand when the surgeon requires it? Generally, the family doctor.

But an estimated 70 per cent of all Blue Shield plans pay only one fee for surgery, and of course it goes to the operator. So who pays the family doctor for his assistance in such cases? Generally, the surgeon.

In other words, the surgeon has to collect the insurance benefits and divide them with his assistant. Technically, this is fee splitting—and many doctors are increasingly unhappy about being forced into an apparent violation of their ethical code.

"In the past few months," Dr. Paul R. Hawley, director of the American College of Surgeons, h said, "I must have been asked t times, 'What are the insurance co panies—the commercial carriers well as the nonprofit plans—going do about fixing a pattern for t ethical division of fees?'

"It is rather encouraging to me find out how many men doing su gery shudder even at [forced di sion of insurance fees], althoug that is obviously not against the p tient's interest at all. They feel gu ty; they feel that their hands are n clean; and they ask me repeatedl to try and get Blue Shield to wo out a formula whereby the fees pa can be honestly and ethically divi ed [with] outside assistants."

Actually, the problem is by n means limited to surgeons and the G.P. assistants. It crops up in th great majority of two-doctor an three-doctor cases where the patie has insurance. Dr. E. L. Bernhar board chairman of the Blue Shie plan in Milwaukee, cites these fairly common examples:

"A surgeon will call an interni

By R. Cragin Lew

**This article explores one more aspect of fee splitting, a subject that has been opened up for discussion in the past four issues of this magazine. The views expressed here stem largely from the 1952 annual conference of Blue Shield plans, held in San Francisco.*

to control a diabetic patient; an obstetrician will require consultation in connection with a caesarean section; an orthopedic surgeon doing a spine fusion may have a surgical team-mate to perform the removal of autogenous bone for grafting."

In most such insured cases, just one fee is forthcoming. Which means the doctors have to divide it according to their own improvised formula.

What many of them want, instead, is a standard Blue Shield formula under which (1) the doctors will be paid separately; (2) each doctor will receive a fair share; and (3) the patient will know "who gets how much for what."*

Can such a formula be devised?

The question is becoming important to nearly all doctors, in view of the rapidity with which insurance coverage of surgery is growing. Before long, as A.C.S. Assistant Director Stephenson points out, a typical surgeon may well say: "Seventy or eighty per cent of my work is done under Blue Shield or some other prepayment plan which does not allow me to practice ethically."

Three-Way Choice

Signs are, however, that a solution is close at hand. Of the various formulas for allocating Blue Shield fees, tested in different areas, here are three:

1. *Have Blue Shield pay an assistant's fee in addition to the scheduled surgical fee.* This has been seriously considered in Milwaukee, then sidetracked as "actuarially unsound and open to abuses." It has been tried in Massachusetts, with strikingly similar conclusions.

Early in the history of Massachusetts Medical Service, says Dr. Charles G. Hayden, the plan's executive director, "it was recognized that in certain areas . . . it was common practice for the family physician to assist the surgeon and provide the after care. It was also recognized that specialists from the Boston area were called out into the state to operate, and that under such circumstances the family physician or a local surgeon assisted and provided the after care."

To help finance such services, Blue Shield arranged a schedule of "supplemental allowances." These were earmarked for the assisting M.D.; and they came out of the Blue Shield treasury, not out of the surgeon's fee.

Under one indemnity-benefit plan that went into effect in 1951, for example, the amounts allotted to the two doctors compared thus:

Surgeon's Fee	Assistant's Allowance
$75-100	$17
$101-150	$22
$151 up	$27

The hitch was that these "supplemental allowances"—being merely tacked on to the existing fee schedule—added too much to the plan's operating cost. There was even some

*This is the key requirement of the American College of Surgeons, as paraphrased by Dr. George W. Stephenson, assistant director.

talk that they encouraged "feather-bedding," since the same services were worth more when two doctors performed them than when one did alone. At any rate, the plan's policy-makers decided last fall that such allowances could not be defended. They were forthwith abandoned.

2. *Have Blue Shield pay the assistant a variable part of the scheduled surgical fee.* This is the arrangement now used in Milwaukee, and it seems to be working well. Surgical Care, the local prepay plan, divides the total allowed fee in any way the doctors choose. Then the plan pays each doctor accordingly.

After the surgeon has submitted his first report, he receives a letter explaining the procedure. The letter runs something like this:

"The Surgical Care fee for the services described is $125. In cases where more than one doctor attends the patient, Surgical Care pays the scheduled fee in accordance with instructions received from the doctors rendering the services. Will you please indicate your instructions below?"

A similar letter goes to the assistant, and the two responses are matched up. Finally the scheduled fee is divided pro rata—say, $90 for the surgeon, $35 for the assistant—and separate checks are mailed out. The patient (or subscriber) is also notified as to what fees are being paid.

This system meets every legal test, according to Blue Shield attorneys. "The concept of secret commissions between physicians is al viated by such a procedure," th report. "The present method of d viding a fixed fee . . . does not vi late the [state's] fee-splitting stat ute."

The method does, however, lea the division of the fee entirely up t the two doctors—an option th many medical leaders don't thi they ought to have, especially if th patient has been referred from on to the other.

A sounder solution, from thi point of view, may be the following

3. *Have Blue Shield pay the a sistant a fixed part of the schedule surgical fee.* Massachusetts Medic Service has come around to thi scheme, after agreeing on these un derlying principles:

¶ "Allocation of fees betwee family physicians and specialists [is] not considered to be unethical i those instances where the formul for such allocation [is] known to al parties—the patient, the family phy sician, and the specialist."

¶ "Allocation of fees on a percent age basis would seem to be the sim plest and most understandable for mula."

How, then, does the Massachu setts plan work? Briefly, it allocates 15 per cent of the scheduled surgi cal fee to the family doctor when the latter assists at the operation; and it allocates another 15 per cent to the family doctor when he pro vides the after care.

Thus, when the G.P. performs both functions in connection with a

$75 operation, the plan pays him $22.50. When it's a $300 operation, the plan pays him $90. If he assists but doesn't provide the after care (or vice versa), he's paid half those amounts. In each case, the surgeon receives what remains of the total allowed fee.

The G.P. also gets special treatment in the matter of reports. "Because surgeons are sometimes not very prompt in reporting their cases," says Dr. Hayden, "and because surgeons sometimes forget to mention that a general practitioner actually did provide the after care, or assisted, we also permit the general practitioner to send in a form." As soon as this report is received, the assisting doctor is paid.

Will some formula acceptable to doctors everywhere emerge from these three experiments?

Blue Shield itself isn't forcing the issue. In the spring of 1952, the Blue Shield Commission listened attentively to a plea from A.C.S. Assistant Director Stephenson that it "cooperate in solving the problem by working out administrative procedures" for the ethical division of fees. But the commissioners decided instead that "Blue Shield plans should not become involved, but that the professional organizations should solve their own ethical problems."*

Which puts the matter up to the sponsoring medical societies—in other words, to doctors throughout the country. Whatever fee pattern they decide is best will undoubtedly be adopted by Blue Shield. END

*Just recently, the Blue Shield Commission eased this hands-off policy. It now supports the adoption of "administrative procedures that will make a proration of fees for surgical services possible in an ethical manner."

When Is a Doctor?

• While filling my gas tank the other day, the service-station attendant remarked that his wife was ill and asked whether I made house calls.

"Not very often," I told him. "Because of my specialty I work mostly in the hospital or office."

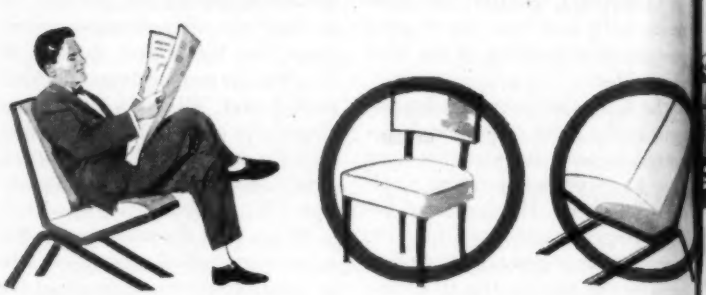
I could see that the idea of specialization puzzled him. So I went on—ill-advisedly—to explain about boards, certification, referrals, etc.

He made no comment until I'd finished. Then as I was about to drive off, he eyed me skeptically and said:

"But you're still a doctor . . . aren't you?"

—NATHAN FLAXMAN, M.D.

Why Patients Don't Come Back



If they fade away after a first visit, then the fault—let's face it—may be yours

● During recent months, I've asked the same question of over a hundred men and women: "Have you ever gone to a doctor once or twice and then dropped him?" With those who said they had, I went further. "Why?" I asked. "What's been wrong?"

Their answers are illuminating.

Some patients, of course, dislike a doctor no matter what he does. They're prejudiced from the outset, and that's that.

"He looked exactly like a neighbor we'd had back in Ohio," one woman remarked. "*That* man was the biggest gabber in five counties. It was silly, of course, but I couldn't overcome a fear that this one might broadcast everything I told him."

"The doctor had an English accent," one man said, laconically. "Never *could* stand an English accent."

The chances are that the patient who develops an unreasonable antagonism toward a physician will be a woman. If your practice is made up largely of women, then, perhaps you can write off the occasional defections.

But most patients desert their physicians for more valid reasons. Here are the major ones, arranged according to the frequency with

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By David Rutherford

**The author, who writes here under a pen name, is a clinical psychologist on the staff of a state hospital.*

which they seem to occur and the relative seriousness that patients attach to them:

The doctor failed to inspire confidence in the patient.

The physician's mannerisms and professional methods are much more likely to influence the patient than either his appearance or his speech. "Of course I like a doctor to look neat and use correct English," one woman told me, "but I actually don't care too much about baggy pants or an occasional disregard of grammar if he convinces me that he knows what he's doing."

There are three major ways in which a physician can fail to "convince" his patient.

1. He can act edgy, as if on the verge of a breakdown. He can, that is, become irritated over small things, lose his temper with an assistant, or drum his fingers impatiently over slight delays. Or he can simply allow his voice to betray a general lack of emotional control.

2. He can display an inability to think clearly. Some doctors, for instance, forget where they've left their instruments a moment after putting them down. Or they ask questions of the patient, forget the answers, and have to repeat them. Or they begin some activity and absent-mindedly leave off before completing it.

The patient's reaction to all this is probably best summed up by one man who told me: "When a doctor examines me, I want to have his undivided attention and I want to be able to leave his office with the feeling that he hasn't missed a thing. If I can't feel that way about him, I won't come back."

3. He can permit the patient to suspect that his symptoms baffle the doctor. By and large, patients don't demand infallibility; but when it comes to their personal health and survival, they prefer to see as few indications as possible of the physician's tendency to err.

Such indications include excessive head shaking or head scratching, or frequent use of common expressions of bewilderment like "Now this is something I hadn't expected . . ." or "Mmmm, I wonder now . . ." I know of one doctor who probably doesn't realize how many patients he's lost

because of a favorite little joke of his: "Well, let's try this medicine, and if it doesn't kill you, I guess we'll have to call it a cure."

In short, the people I talked to appeared to prefer the kind of physician whose own emotional control is good, whose mind is obviously on what he's doing, and who's smart enough to keep most of his perfectly human doubts to himself.

Explain Things

The doctor failed to answer questions that had been bothering the patient.

Time and again, people I interviewed said, "I didn't get any *satisfaction* out of that first visit. That's why I didn't go back."

Some practitioners so completely dominate an interview that the patient never gets a chance to touch on the urgent worries that brought him to the office in the first place. Others listen but remain infuriatingly noncommittal, as if to imply "There's no need for *you* to know what's the matter with you, Mrs. Brown, as long as *I* know."

Still other doctors answer questions, but do so in medical terminology that causes the patient to conclude: "I could have made more sense out of hieroglyphics."

Doctors can't tell patients everything, of course. But the physician whose patients come back is the man who answers questions clearly, simply, and carefully. When such a doctor is unable to provide the information requested, he offers good reasons for not doing so—plus some assurance.

The doctor gave the patient reason to feel that the time devoted to the first visit was well spent.

One busy mother outlined the situation graphically: "I have so little time away from my home and children that I want to put it to good use. The two hours I spent in the doctor's office seemed an appalling waste to me. I had an appointment, but I waited over an hour in his reception room. When I finally got to see him, I found out why. The man knew more ways to kill time than Major Hoople. During the examination, he paused to tell me about his dahlias, to straighten a picture frame, to show me a photo of his daughter, and to read me an editorial from the morning paper. It was all very social—and wildly irritating.

"Worst of all," she added, "when his receptionist managed to convince him it was time to see the next patient, he still hadn't completed my examination. He had to give me a second appointment for something he could easily have finished in the first. I took the appointment, but I didn't keep it."

"Every minute I spend in a doctor's office," said one man, "is a minute away from my business. I don't mind if I feel the time is being put to good purpose, but I don't want to see it wasted."

Many doctors apparently overlook the pressure on patients of parking meters, traffic jams, time clocks,

business competition, and transportation schedules. There are undoubtedly a few dowagers who *want* to find ways to kill their afternoons; but it's safest to assume that patients are busy people, interested in spending as much time as necessary in the doctor' office, but no more.

Most patients favor the practitioner whose office equipment is conveniently arranged to avoid waste motion, whose routine is so carefully worked out that they don't have to trot back and forth from room to room or constantly remove garments that they've just replaced, and whose social remarks are held down to the minimum for putting patients at ease.

One woman told me about a doctor with whom she *does* keep appointments: At the end of an interview, he always summarizes exactly what has been accomplished. "This gives me a feeling," she said, "that something has really been done during each visit. As a result, I always go back for the next."

Don't Expose Them

The first visit proved too embarrassing for the patient to want to return.

Few doctors *want* to embarrass their patients; but they sometimes do it unwittingly in any one of the following ways:

¶ By moralizing. Physicians find out a lot about patients that society as a whole might not approve; and sometimes they can't resist giving a lecture. The chances are that a patient will resent this. "Scientific advice I can take," one man remarked. "But the 'Now-I-certainly-think-someone-ought-to-talk-to-you-about-that' approach usually makes me feel a fool. And I don't go to a doctor's office to feel foolish."

¶ By asking intimate questions too abruptly and directly. The safest way is to begin with the least embarrassing material and work gradually toward the most intimate. By this method, the patient becomes accustomed to the questioning and is spared embarrassment.

¶ By responding too emotionally to what the patient says. The safest emotions to register are sympathy and goodwill. The most dangerous are horror and disgust. When in doubt, the doctor should try to look blank—the blanker the better. (And watch that tongue, too. "If my doctor clicks his tongue at me once more," one woman said, "I'll leave him for good!")

¶ By kidding a patient about his run-down physique, his bay window, or, worse yet, his bowlegs. One doctor has this standard joke for his more portly patients: "Just a minute while I run out and get some insurance for my scales." As one ex-patient remarked, he really needs more insurance for *himself*, because some fat man is likely to kill him some day.

Interestingly enough, most people apparently don't feel too embarrassed about having to strip in a doctor's office—as long as they believe it's necessary, and as long as the doctor remains [MORE ON PAGE 159]

Yardsticks for A Community Hospital

If you're asked for advice, here are some basic rules for determining need, size, location, costs, financing

● The layman automatically assumes that his physician is an authority on everything connected with the practice of medicine. So when the subject of a new community hospital arises, you're expected to provide ready answers to such questions as:

¶ How big should the hospital be?

¶ What would it cost?

¶ How do you go about getting it built?

While few practicing doctors have the time or background to master the principles of hospital construction and design, there are some rules-of-thumb that any M.D. can apply in his own community. These won't replace a careful survey by qualified experts. But they can help clarify some of the basic problems.

First of all, they can serve as a traffic signal: Does the community really need a hospital enough to go

By Peter S. Nagan

KENT COUNTY MEMORIAL HOSPITAL, WARWICK, R.I. HOWE, PROUT, AND EKMAN, ARCHITECTS

ahead with the project? If so, is it financially able to build—and support—the kind of hospital required? Given a few facts about population, existing hospital facilities, and relative income and health levels, you can even work out the rough dimensions of the hospital your community should build.

Of necessity, the rules-of-thumb available work ideally only for the mythical "typical" community; and the odds are that yours isn't typical. But for preliminary calculations, the differences probably won't matter too much.

There are two standards by which most communities can test their *need* for new hospital facilities:

1. Is there an adequate general hospital within twenty miles of the community—or within an hour's drive?

2. Do existing local institutions have enough general beds to maintain a ratio of 4.5 per 1,000 population?

If the answer to either question is "Yes," a brand-new hospital may not be necessary. It should be noted, though, that the 4.5 figure is only a rough guide. Many rural areas can get along with only two beds per 1,000, especially if there's a large medical center not too far away. On the other hand, some cities need six or more beds per 1,000.

Local economic conditions, in-

dustrial hazards, and climate may also be determining factors. But the 4.5 per 1,000 figure will be valid for a good many cases. (If you think the situation in your community unique, you can get a more precise appraisal of need from your state hospital planning agency.)

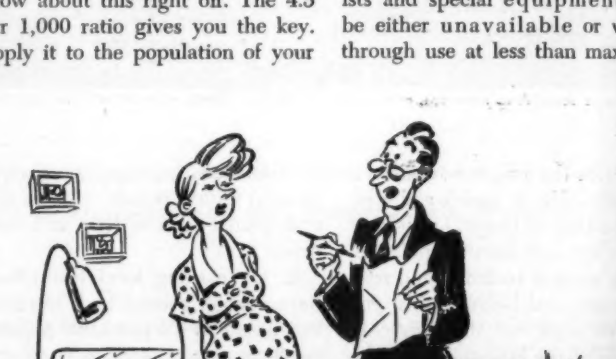
Once you have decided that the need is real, you can begin to think about size, cost, and location. There's a yardstick for each of these too.

How Many Beds?

Your fellow citizens will want to know about this right off. The 4.5 per 1,000 ratio gives you the key. Apply it to the population of your area, subtract the number of existing general beds, and you get an approximation of your need.

Example: If you live in a town of 50,000 population, with an existing 100-bed hospital, the formula will suggest that the town needs 225 beds. With 100 beds already on hand, a new hospital of 125 beds (or enlargement of the old hospital) may be called for.

Any figure you come up with is subject to an important limitation: A general hospital of fewer than fifty beds may not be able to provide adequate hospital service. Specialists and special equipment may be either unavailable or wasted through use at less than maximum



"Now there's one point in this medical policy I'd like to make clear . . ."

efficiency. Where fewer than fifty additional beds are needed, the solution may be simply to add a wing to existing facilities.

Cost of Construction

Designers figure that a hospital should have about 600 square feet of floor space per bed. Local builders and contractors can quote you the prevailing per-square-foot rate in your area. Then you'd better estimate an additional $2,000 cost per bed for equipment.

For a 125-bed hospital, the per-square-foot rate might come to about $25. So the cost of the building alone would total $1,875,000 (125 x 600 x $25). The equipment cost would come to another $250,000. Fees paid to architects, engineers, and consultants, might tack on another $125,000. So you could figure the total cost at something like $2,250,000—or about $18,000 a bed.

How to Finance It

You don't always have to meet all the construction costs of a hospital with local funds. Many states are assisting individual communities with substantial grants—in some cases, matching the local contribution dollar for dollar. In addition, the Federal Government is spending some $75 million a year to foster hospital construction under the Hill-Burton Act. Since the Government will put up anywhere from half to twice the state-local total, a community's share may be as little as one-sixth the ultimate cost.

There are, of course, some strings to this outside money. Both state and Federal governments insist that the hospital meet certain standards of need, location, and construction. And even when all these conditions are met, Federal funds may not be granted; because rural or depressed areas, and those critically short of hospital facilities, have a prior claim on Hill-Burton aid.

Cost of Operation

Hospitals customarily calculate operating costs on the basis of the average percentage of beds occupied. Let's assume that what your community wants is a private, short-term, non-profit hospital. Here's the average daily occupancy rate for such institutions in 1951:

Under 50 beds	59.9%
50-99	67.1
100-249	75.9
250 and over	79.4

The average cost to a hospital of a single patient for a single day also varies with the number of beds. Here are the 1951 figures for the same class of institutions in terms of daily cost per patient:

Under 50 beds	$14.78
50-99	15.66
100-249	17.76
250 and over	19.70

Thus, for a 125-bed hospital, the average daily occupancy is about ninety-four beds. At a daily cost to the hospital of $17.76 per patient, the daily total equals $1,669. Cost of a full year's operation, then, is about $610,000. [MORE ON PAGE 153]

Correct Conduct in Consultations

• Ever read the Principles of Medical Ethics? Remember in detail what they say? Got a copy of them on hand for ready reference?

If you can answer yes to each of these questions, you're one in a thousand. *Hardly any* physicians in a sample queried by this magazine could do more than guess the answers to specific ethical problems posed. Hardly any had a copy of the A.M.A. principles on file in their offices.

This needn't come as too much of a surprise, though. For few doctors would, by choice, wade through the small print of the chapters and sections that comprise the code.

Yet the fact remains that a knowledge of what's in the code is important to every medical man in practice.

To bridge the gap and make this knowledge available in easily assimilable form, MEDICAL ECONOMICS is initiating a new series that will give you the highlights of the official rules of conduct. Herewith an installment on consultations and referrals.

All quoted material is taken directly from the A.M.A. Principles of Medical Ethics.

When should a doctor request consultation?

"In a case of serious illness, especially in doubtful or difficult conditions . . ."

What data should he give the consultant?

". . . a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service . . ."

If a consultant is delayed, what then?

"When . . . one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed."

When may the consultant examine the patient in the family doctor's absence?

"When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends . . ."

[MORE→

What may the consultant tell the patient?

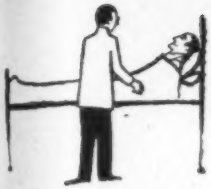
"Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement."

What data should the consultant give the family doctor?

If the consultant has seen the patient in the family doctor's absence, he should, "as soon as possible" thereafter, "address the physician in charge and advise him of the results of the consultant's investigation."

But what if the doctors disagree?

Then "another consultant should be called or the differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge."



Who is responsible for treatment?

"The physician in charge of the case . . . Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted."

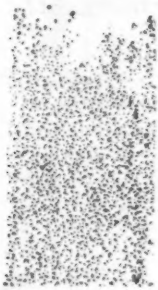
What if the agreed-upon treatment is changed?

". . . after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference."

May the consultant become the physician in charge?

". . . he should not . . . except with the consent of the physician who was in charge at the time of the consultation." However, "when an emergency occurs . . . a consultant may assume authority until the arrival of the physician in charge . . ." END

A New Era for the G.P.?

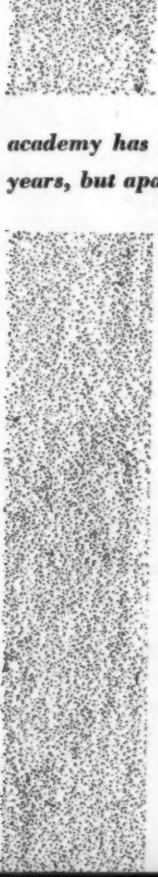


By Roger Menges

His academy has come a long way in five years, but apathy is still a problem

● If a medical student isn't particularly intelligent or aggressive, he should "be advised to go into one of the specialties."

This view, as expressed recently by Dr. J. P. Sanders, past president of the American Academy of General Practice, is not an uncommon one in G.P. circles today. But can you imagine anyone seriously suggesting it a half dozen years ago—at a time when the general practitioner's stature had apparently shrunk to something less than that of a circus midget?



Valid or not, opinions like Dr. Sanders' reflect a revival of self-confidence or at least self-assertiveness among G.P.'s—a revival evidenced in a variety of ways. Some recent examples:

¶ In Kansas City, architects are working on plans for a $350,000 building, the future headquarters of the American Academy of General Practice.

¶ In St. Louis, a newly formed city-wide emergency call service is financed, directed, and staffed exclusively by G.P.'s.

¶ In Chicago, the A.M.A. has decided that in future editions of its American Medical Directory A.A.G.P. membership will be indicated in the same way as membership in specialty societies.

¶ In Seattle, G.P.'s have initiated the formation of an intraprofessional council to iron out problems between themselves and specialists.

¶Canadian and British G.P.'s, noting the progress of their colleagues here, now want help in setting up their own general practice organizations.

Do such instances hold promise of a new era?

Could be. They're reflections of a vigorous effort being made by the A.A.G.P. to help the general practitioner regain his place in the medical sun.

It's true that the academy hasn't worked miracles, that its membership remains limited, that its achievements are due largely to the efforts of only a small proportion of G.P.'s. Nevertheless, it has made some impressive strides since its birth in 1947. Take the hospital situation, for instance.

Hospital Successes

In many ways, the G.P.'s place in the sun depends on his place in the hospitals. The 150 family physicians who founded the academy were well aware of this. Every qualified G.P., they declared, should be on a hospital staff and should have the privilege of treating his patients there.

To bring this about, the academy has been campaigning for a general practice section in each well-departmentalized general hospital in the country.

The reasoning is obvious: With a department of his own, the G.P. is on the same footing as other men on the active medical staff. He has a voice in hospital-staff affairs and can expect support from his own department in the event of misunderstandings.

The campaign has been pretty successful so far. In the four years from 1947 to 1951, the number of general practice departments doubled. By 1951, according to the A.M.A. Council on Medical Education and Hospitals, 35 per cent (1,660) of all general hospitals had set up such departments. About three-quarters of them were patterned after the academy's recommendations, as set forth in its "Manual for the Establishment and Operation of a Department of General Practice in Hospitals."

The going may be slower from now on. Last year, only a handful of hospitals were won over. But, as academy leaders point out, there are fewer and fewer instances of G.P.'s being excluded from hospital staffs.

Not that the situation is com-

pletely rosy. The academy's commission on hospitals hears constant complaints of dissatisfaction, disunity, and troubles on hospital staffs all over the country. A large share of these complaints come from G.P.'s who feel they're unduly restricted in the in-patient work, particularly surgery, that they're permitted to do.

The academy and the American College of Surgeons agree pretty much on standards for surgery. Yet, says the academy's hospital commission, "the interpretation of these principles by inspectors of the college and by hospital administrators and governing boards sometimes appears to be aimed at limiting surgical privileges to specialists certified by the American Board of Surgery or to fellows of the American College of Surgeons."

"It's not right for a man in Chicago to tell a man in Baltimore whether or not he can do surgery," says Dr. John O. Boyd Jr., chairman of the commission. Both the A.M.A. and the A.C.S. agree with the academy in principle that hospital privileges should be based on individual ability.

But academy members differ even among themselves as to the scope a G.P. should have. The commission warns that such differences should not "encourage us to accept limitations in general practice which are arbitrary. If we allow ourselves to exclude surgery from general practice, we are playing directly into [the specialists'] hands . . . If, on the other hand, we allow ourselves to unreservedly say that every general practitioner shall do major surgery, we will be untrue to the basic principles which led to the formation of the organization."

Specialists to Blame?

The chief roadblock in the G.P.'s quest for hospital privileges, says one A.A.G.P. official, is the middle-aged specialist. "We hear few objections from men over 55 or from young men just finishing residencies. The former have reached the stage where they feel secure, and the latter still realize that proficiency rather than paper qualifications is the important thing.

"But a man out of residency five years doesn't feel secure yet and is apt to stand in the G.P.'s way. It's the old union idea pure and simple. You can dress it up any way you want, but it's still unionism."

Another roadblock is the G.P. himself. In the end, most hospital troubles must be settled at the local level. But many local G.P.'s are not well-enough organized to make their weight felt. "Where the G.P.'s as a group take an active interest in their community hospital," says the commission, "satisfactory staff organization and privileges are usually worked out."

Sometimes, too, G.P.'s are satisfied with the privileges they have and are reluctant to push for a department of their own. "This is poor judgment," says a commission member, "because the specialists could

always set up restrictions that could do away with the G.P.'s privileges. Then he'd have no staff organization to fall back on."

In general, though, G.P.'s are developing a more militant attitude. Consider the case of Miami's year-and-a-half-old Mercy Hospital:

While the hospital was still in the construction stage, its governing board had already decided to form only specialist sections. The Dade County A.A.G.P. chapter protested, but without success.

Then, one day, a local G.P. happened to tell an influential patient that the new hospital was to be primarily for specialists. "If I'd known that," replied the patient, "I'd never have donated to their fund-raising campaign. If you like, I'll write a letter of protest to the hospital board."

This inspired other local G.P.'s to lay the case before their patients. Before long, several hundred Miami citizens, many of whom had contributed to the hospital building fund, had protested to the hospital authorities. Since a second fund-raising drive was in the offing, the protest worked. A general practice section was formed; and when the hospital opened, in April, 1951, some 140 G.P.'s were on its staff and were represented on its executive board.

Study Opens Doors

Though organized efforts have produced telling effects in other places as well, the key factor in the G.P.'s hospital successes is his own self-improvement, the academy says.

To keep his academy membership, a G.P. must devote 150 hours every three years to refresher courses, medical meetings, and the like. The academy is the only medical organization that requires such continuing post-graduate work.

To make it easier for members to meet requirements, most state G.P. chapters sponsor clinical sessions and conduct their own P.G. courses. For doctors who can't attend regular sessions, the academy is developing home-study courses. It's also experimenting with the idea of a library of recordings, movies, and slides.

Even so, the requirements have proved too stiff for a number of doctors. Nearly 1,000 have had to be dropped from the academy's rolls because of failure to chalk up the necessary P.G. credits.

Schools Still Cool

One place where the G.P.'s stock remains rather low is the medical schools. From 1938 to 1950, the U.S. lost 13 per cent of its G.P.'s, while its population increased 15 per cent. Meanwhile, the number of specialists almost doubled.

Many institutions are still geared mainly for turning out specialists. But a slow evolution seems to be under way.

For one thing, some fifty-four schools now have programs to interest and prepare students for general practice. At least twenty offer

preceptorships in which undergraduates get on-the-spot training from near-by G.P.'s.

Other medical schools, like the University of Tennessee and the University of Pennsylvania, have set up clinics that simulate the conditions of general practice. Each participating student is assigned a family, which he visits regularly and helps care for in clinic, hospital, and home.

In some places, G.P.'s are going out of their way to whet the students' interest in general practice. In Seattle, for example, they recently invited seventy-five students from the University of Washington to be their guests for a day of scientific and clinical sessions, topped by a banquet.

As the schools put more emphasis on general practice, more G.P.'s find themselves on teaching staffs. At the University of Tennessee, for example, the faculty includes thirty-three G.P.'s. These men run the outpatient clinic and supervise emergency admissions—probably the first time G.P.'s have been given the responsibility of screening patients for a major medical center.

Although there are no over-all facts about the effect such programs are having, the academy reports that more and more embryo doctors are becoming general-practice-conscious. At the University of Pennsylvania School of Medicine, for instance, nearly 100 students have formed a general practice society.

"Once we've inspired the student as to what the complete personal physician can be," says Dr. Merrill Shaw, chairman of the A.A.G.P. commission on education, "he'll see that general practice offers him the greatest challenge."

Students may be more willing to accept that challenge if they know there's a solid organization behind them. As one surgeon said recently: "If the academy had been in existence seven years ago when I was making up my mind, I would have gone into general practice. It's about time the G.P.'s wised up to an elementary fact that's common knowledge, even to teen-agers: In the world of today, you can't stand alone."

Have the G.P.'s really "wised up"? Are they ready to wield the influence their numbers warrant?

Not quite, apparently. Perhaps the least impressive of the academy's strides has been in its drive for new members. In 1948, a year after it was launched, membership stood at 3,000. Today, it is about 15,000.

This may seem like a rapid growth. But with each succeeding year, fewer new members have been added to the academy's roster. In 1951, membership increased by only about 1,500. At that rate, it may be decades before the academy corrals a sizable proportion of the country's 86,000 G.P.'s.

One reason for the low recruiting rate is its stiff P.G. requirement. Another is the slowness with which its chapters [MORE ON PAGE 157]

ll in his city clothes, Kenneth Kaisch is welcomed by Philip townspeople

He Moved to the Country

Many thorns among roses,' says this former city doctor —but he doesn't regret it

by Don Cameron

● Many a young doctor, breathing hard in the impersonal atmosphere of a big city, dreams of a country practice. Some do more than dream.

Thirty-year-old Kenneth Kaisch, once a G.P. in Detroit, belongs to this latter group.

Now, after two years as physician to the little town of Philip, S.D. (pop.: 900), Kaisch is glad he moved—even though some of the rural realities have proved unexpectedly rugged. As he sums up his ex-

perience so far, many of his disappointments are like those of a gardener measuring blooms by seed-catalogue promises: They'd be less painful without the comparison.

"Still in all," says Kaisch, "if I decide to move again, I'll look for another small town. I've had some bad times here, working up to twenty hours a day without adequate facilities—but things have never been bad enough to make me sorry I didn't stay in the city."

Ken Kaisch didn't always lean toward a country career. Graduated from the University of Michigan in 1946, he took a residency in pediatrics for a year and a half following his interneship. Then he decided he was more interested, after all, in general practice; and when his residency ended, he tried it out with another doctor.

The City's Drawbacks

The grass-roots idea, a mere vagary to begin with, grew in charm against the backdrop of industrial Detroit. As a young doctor with a family to think about, Kaisch became increasingly aware of the unfriendlier aspects of the metropolitan scene. Among them, he lists:

¶ The "fierce" competitiveness;

¶ An absence of the personal element in many physician-patient relationships, which nearly eliminates one of the most satisfying features of medical practice;

¶ The difficulties encountered by a new member of a hospital staff in obtaining beds for emergencies.

These considerations, mainly, were what prompted Kaisch and his wife to seek greener pastures. Combing the Physicians Wanted ads in the Journal A.M.A., they knew what they were after: a small Western community with a stable population, good schools, an adequate hospital and decent housing and office space for rent. Once they had unearthed three promising leads, the Kaischs set out on a tour of inspection.

The Town's Appeal

Philip, 1,200 miles away, was the first stop. Kaisch liked the prospect of hunting and fishing within fifteen minutes of the heart of town. He did not like the nine-bed, five-bassinet hospital that occupies an old frame house. But he found nothing better farther on.

As towns go in the sweep of high butte-broken prairie that skirts the Dakota Bad Lands and gets lost in the Black Hills a hundred miles west, Philip has its good points. The seat of Haakon County (pop. 3,000), it draws trade from a fifty-mile area of farms. The nearest doctors, Kaisch learned, were twenty-six miles south and fifty miles west. Housing was satisfactory.

The forbidding feature, for Kaisch, was the sorry state of practice facilities. The only office available was a room in the hospital. In the hospital itself, fracture patients had to be carried to and from the X-ray and cast rooms, and there was only the most primitive laboratory equipment. Even more serious was

the lack of competent nurses and medical technicians.

But members of the hospital board and other leading citizens had reassuring news. "I was told," says Kaisch, "that preliminary work on a modern hospital was already in progress and construction would start soon. The dentist wanted to put up an office building for himself and the town doctor. The future *sounded* bright enough to justify an indulgent attitude toward the present."

He Made the Break

In July, 1950, therefore, Kaisch became the fourth doctor in ten years to begin practice in Philip. He *found* the people friendly and practice brisk. With better facilities in prospect, he saw no reason to doubt that he had made a happy choice. Not right away, that is.

Hitherto unsuspected facts of Philippian life revealed themselves gradually: Having rebelled against Detroit's feverish pace, Kaisch was pleased to find it nowhere evident in Philip—until, one day, he realized that *he* was working harder than ever. Meanwhile, rising costs had changed the dentist's mind about building offices; and it turned out that the only preliminary "work" on the new hospital had been verbal.

Two years brought no improvement. However, there is now a chance that something will be done. A proposition to build a hospital under the Hill-Burton Act may soon be submitted to the county voters. If they approve the hospital bond issue, Kaisch has said, he will gladly go into debt to build an office.

That would make a big difference, he feels. "Not having an adequate hospital hampers my work in every way. I treat emergencies in my present delivery room, but would hesitate to do any elective surgery there. Except for minor procedures, my surgery must go to Pierre or Rapid City, ninety miles east or west."

Referrals Lose Patients

And city referrals mean lost patients. "When I send a patient for treatment of a specific condition," says Kaisch, "he is apt to be treated for other things that *I* could have handled. A man I referred out for removal of a piece of steel embedded in his eye also had several cysts removed from his neck. A woman sent for a Caesarean section was told to bring her baby back to the pediatrician, even though my own pediatric training fully qualifies me to tell a mother how her child is doing.

"The city specialists seem to consider the rural G.P. merely a referral station. My patients receive prompt attention, and as a rule I get a letter stating what was found or done. But consultation in the usual sense is virtually non-existent—partly, of course, because of the distance involved.

"The most disheartening result is that my neighbors, seeing so many of my patients referred out, tend to think of the city man as the better

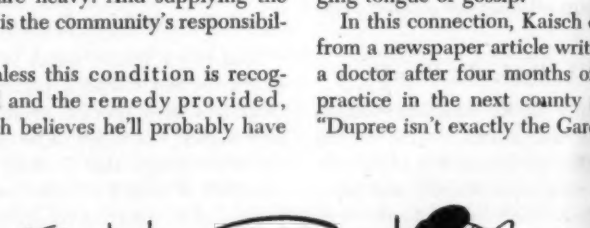
doctor. A physician goes into rural practice partly because he hopes to be able to do more for his patients through knowing them personally. When he finds them looking to him for emergency care, but taking their chronic complaints elsewhere, the effect can be pretty grim."

Given the tools to work with, Kaisch thinks, the small-town practitioner can dispel this impression. Without the tools, the odds against him are heavy. And supplying the tools is the community's responsibility.

Unless this condition is recognized and the remedy provided, Kaisch believes he'll probably have to leave Philip. If he goes, it will not be because he is disillusioned about rural practice, but only about one tiny geographical unit.

Not that a new hospital would transform Philip into a doctor's paradise. Kaisch has taken note of other imperfections, common to all towns but more apparent in small ones. Ugliest of them—and hardest to deal with—is that perennial feature of the rustic milieu, the wagging tongue of gossip.

In this connection, Kaisch quotes from a newspaper article written by a doctor after four months of rural practice in the next county north: "Dupree isn't exactly the Garden of



"If I could *afford* a psychiatrist, I wouldn't *need* one!"

Eden; but snakes lurk here too . . . snakes with two feet, and a foul mouth, spreading rumor after rumor and enlarging on them as they go along . . . "

Noting that these words were *not* aimed at Philip, Kaisch nevertheless observes: "Any newcomer to a community is bound to be thoroughly discussed. But only in a small town must the doctor hear tales of his 'mistakes' magnified and distorted by multiple repetition."

The city physician, he points out, seldom has to face this problem. "An older doctor in Detroit told me that early in his career he was well advised to leave a small town because his skin was not thick enough. My advice to a doctor contemplating a rural move is: Be so far above reproach that the most malicious gabbers can find no fault. Or develop the hide of a rhinoceros."

As much a part of the rural tradition—and as true to life, in Kaisch's experience—is the picture of the harassed doctor *always* at the community's beck and call.

"Round-the-clock availability is, of course, part of the doctor's bargain when he takes over an isolated practice," Kaisch declares. "There's no substitute for his skill and knowledge when they're needed.

"But a doctor can also be nudged toward an untimely grave by thoughtless people who take unnecessary advantage of the fact that he can always be reached. I often go to the office late at night to see some farm child who wasn't brought to town earlier because the trip would have interrupted its father's work. Any number of needless odd-hour calls are made to suit the patient's convenience, with never a thought for the doctor's."

Kaisch's working day varies from eight to twenty hours, depending on the weather and the baby crop. He measures his leisure in hours, not days. His vacation this summer probably will be no more than a long week-end, with the nearest doctor covering emergencies and deliveries.

Despite the dark spots, though, Kaisch feels that his situation in Philip is, potentially, as favorable as any he would find in a similarly isolated town of comparable size. His practice brings in annually around $15,000 gross, $10,000 net; and a new hospital would increase the figures.

Taking one consideration with another, his experience has convinced him that the country doctor's lot can be a happy one. He believes that the disadvantages of rural practice are easier to change, or to tolerate, than those of the city. And, he insists, the satisfactions go deep.

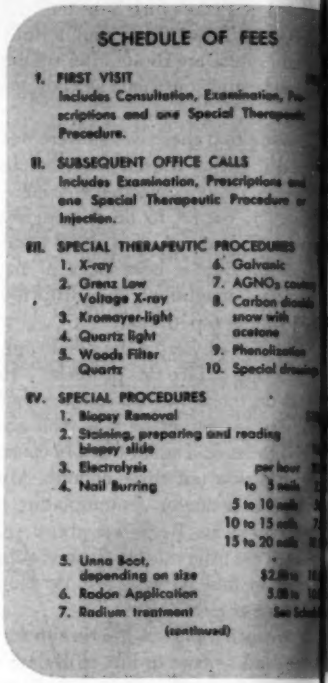
Here is how he summarizes some of the good points:

¶ Rural dwellers are generally more stable than their opposite metropolitan numbers. Knowing his patients and their histories, the doctor can often treat them more effectively.

¶ Rural sur- [MORE ON PAGE 151]

Booklet Solves Fee Mystery For Patients

By Wallace Croatman



SCHEDULE OF FEES

I. FIRST VISIT
Includes Consultation, Examination, Prescriptions and one Special Therapeutic Procedure.

II. SUBSEQUENT OFFICE CALLS
Includes Examination, Prescriptions and one Special Therapeutic Procedure or Injection.

III. SPECIAL THERAPEUTIC PROCEDURES
1. X-ray
2. Grenz Low Voltage X-ray
3. Kromayer-light
4. Quartz light
5. Woods Filter Quartz
6. Galvanic
7. $AgNO_3$ cautery
8. Carbon dioxide snow with acetone
9. Phenolization
10. Special dressing

IV. SPECIAL PROCEDURES
1. Biopsy Removal
2. Staining, preparing and reading biopsy slide
3. Electrolysis — per hour
4. Nail Burring — to 5 nails; 5 to 10 nails; 10 to 15 nails; 15 to 20 nails
5. Unna Boot, depending on size — $2.00 to
6. Radon Application — 5.00 to
7. Radium treatment — See Schedule

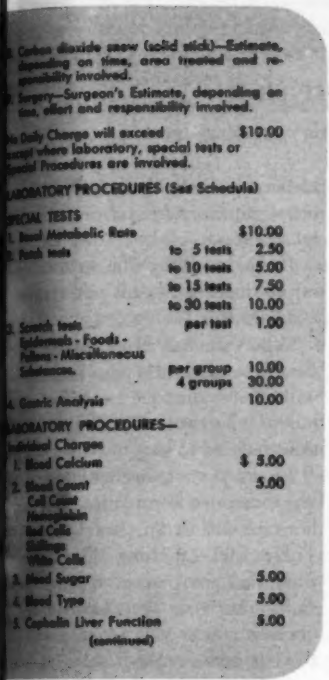
(continued)

• When people grumble about medical fees, they're likely to make two over-all complaints: (1) that doctors are notoriously reluctant to discuss costs in advance; (2) that doctors tend to charge whatever the traffic will bear.

Dr. Paul D. Foster, a Los Angeles dermatologist, has found a way to forestall these complaints. A strong believer in standardized fees, Dr. Foster lists *all* his charges in a ten-page, pocket-size booklet that's handed each new patient arriving at his office. The booklet covers everything from the simplest lab test to a detailed formula for computing charges for radium treatment ("area plus time plus strength equal charge").

Thus the patient sees at a glance that he'll be billed $10 for his first visit, $5 for subsequent visits. As he reads on, he learns the prices of over 100 injections, tests, and special procedures. (Reproduced above are the first two pages only.)

The booklet gives Foster's office



Carbon dioxide snow (solid stick)—Estimate, depending on time, area treated and responsibility involved.

Surgery—Surgeon's Estimate, depending on time, effort and responsibility involved.

No Daily Charge will exceed $10.00
except where laboratory, special tests or Special Procedures are involved.

LABORATORY PROCEDURES (See Schedule)

SPECIAL TESTS

1. Basal Metabolic Rate		$10.00
2. Patch tests	to 5 tests	2.50
	to 10 tests	5.00
	to 15 tests	7.50
	to 30 tests	10.00
3. Scratch tests	per test	1.00
Epidermals - Foods - Pollens - Miscellaneous Substances.	per group	10.00
	4 groups	30.00
4. Gastric Analysis		10.00

LABORATORY PROCEDURES—
Individual Charges

1. Blood Calcium	$ 5.00
2. Blood Count	5.00
Cell Count	
Hemoglobin	
Red Cells	
Siderage	
White Cells	
3. Blood Sugar	5.00
4. Blood Type	5.00
5. Cephalin Liver Function	5.00

(continued)

staff a sound basis for discussing fees with patients, thus leaving the doctor free to concentrate on medical matters. And, he points out, when the patient knows the cost of treatment in advance, he has few grounds for future complaint or ill-feeling. The schedule is tangible evidence, too, that the doctor charges all patients alike.

Even so, he leaves the door open for *reducing* fees when circumstances warrant—as, for example, when a person with low income undergoes prolonged treatment. In such cases, he indicates the reduction in an "adjustment" column of his itemized monthly statement.

But there's seldom an adjustment problem, says the Los Angeles dermatologist, since fees have been set at a minimum level. Typical charges: urinalysis, $2; penicillin shot, $2.50; vitamin shots, $1 or $1.50.

Because of these relatively modest rates, Foster has noticed a slight drop in his gross income since the schedule went into effect at the start of 1952. Still, he's convinced that, in the long run, the idea will pay dividends in improved patient relations. "Patients really seem to go for it," he reports. "The idea has cleared the air on the touchy fee question. And I've noticed that people are paying their bills more promptly now. This may be partly because, in an introduction to the booklet, I've explained that prompt payments reduce overhead costs and so, indirectly, serve to keep fees down. But mainly, I think those prompt payments are the patients' way of saying that they *like* having the mystery taken out of fees." END

How to Buy Life Insurance

If you shop around, says this expert, you can get a better policy for less money

● Not long ago, I asked a sample of educated people—physicians, lawyers, bankers, college professors, executives, and the like—how they chose their life insurance policies.

Know what they told me?

Without a single exception, their decision in favor of any specific policy was based on cost, on the reputation of the insurance company, and/or on an emotional reaction to the salesman or his sales pitch.

What amazed me was that none of them seemed to care about the contract provisions of the policies themselves. They tended to brush off differences in the provisions as so much sales talk.

No wonder that 92 per cent of these people—as I discovered after examining their policies—had bought life insurance that was actually inferior to what they could have had for the same price, or even less.

The moral is this: Differences in contract provisions are more important than differences in rates.

That old saw about getting what you pay for is not always true in the life insurance field. In fact, you can often get *more liberal* provisions at *lower* rates.

If you have any doubts about the importance of liberal provisions, consider this:

When you buy life insurance, you usually assume that your beneficiary will receive the face amount of your policy when you die. That assumption may be wrong.

Every year, many widely known life insurance companies deny millions of dollars in death claims. There isn't anything illegal about this. The companies refuse to pay simply because *the claims are not covered* under the provisions of their policies.

Naturally, your first concern is to get protection for your fundamental needs. Keeping this in mind, it's wise to shop for liberal contract provisions. The questions that follow will help you do this.

You may not think that every provision mentioned is of prime importance. But under certain conditions,

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By Robert Scharf, Ph.D

**The author is both an educator and a businessman. He teaches economics at Georgia Tech and he also has his own business as a consulting insurance economist.*

it could be. And the point is, you may as well get the best terms possible if they're available at little or no extra cost—as is often the case.

How long will the policy remain in force if you stop paying premiums?

A well-to-do physician simultaneously took out from different companies two paid-up-at-age-65 life policies of $100,000 each. A year later, when the second annual premiums on the policies came due, he was seriously ill and neglected to pay them. Five months afterward, he died.

His widow collected $100,000 from one company, but the second company refused her claim on the ground that the policy had lapsed.

In this case, the difference between collecting $100,000 and not collecting it lay in the automatic extended insurance provisions of the two contracts. The first company's policy provided extended term insurance for two years and 107 days in the event that the second annual premium was not paid. Thus, when the doctor died five months after the second annual premium came due, the policy was still in full force and would have remained so, had he lived, for a year and more than ten months longer.

The parallel provision in the second company's contract provided extended term insurance for only three months. So the policy lapsed two months before the physician died, and his wife didn't get a cent from it.

Will your policy have a cash and loan value after the first year?

A young doctor bought a $10,000 ordinary life insurance policy when he started out in practice. Unfortunately, he had set up in a town that was over-populated with doctors, so at the end of the first year he found himself deeply in the hole. He couldn't meet his insurance premium, and the policy offered no cash or loan values earlier than the third policy year. As a result, he was forced to drop his insurance and lose the first year's premium outlay.

Another company's policy would have given him a loan value after the first policy year that might have helped him to pay the second year's premium.

Cash values during early policy years vary widely from contract to contract. And a higher premium rate doesn't necessarily mean a higher cash value. For example, here are the second year premiums (less dividends) and cash values of five $10,000 ordinary life insurance policies at age 35:

Premium	Cash Value
$294.00	$40.00
287.50	130.00
278.40	15.00
253.60	None
243.20	304.00

Can the insurance company contest your contract after the first year?

An industrialist bought a sizable policy. Twenty-two months later, it became obvious that he had cancer. Under the contract, the company had the right to contest within two

years. It did contest, and successfully, on the ground that the insured had withheld vital information at the time the policy was taken out.

Most life insurance companies reserve the right to contest for misrepresentation within two years. But it is possible to get a contract with a one year contestability clause. With such a policy, the industrialist would not have lost his insurance. A good point to remember.

Will your premium be waived in case of disability?

At a slight extra cost, most companies will add the so-called premium waiver clause to your policy. Thus, if you become the victim of

a crippling accident or a disabling illness, your premiums will be waived and your policy will remain in force for the full period specified.

But here again is an instance where it's wise to shop for the most liberal provisions. I know a physician who bought a $35,000 life insurance policy some ten years ago. Four years later he suffered a serious heart attack and was advised to cut his working day to a maximum of two hours. Since he wasn't *totally* disabled, he was still saddled with a hefty yearly premium.

Yet, from at least one other company, that unfortunate physician might have got a premium waiver

---

ew Career at 78 Like many another physician, Volney S. Cheney looked forward to the serenity of old age. By the time he was ready to retire, he had completed a notable career as a pioneer in industrial medicine, having been, among other things, the first medical director of Armour & Co., Chicago.

After he gave up practice in 1947, he moved to Las Vegas, N.M. There he prepared to take life easy. But he soon found retirement the toughest job in the world.

A couple of years ago, therefore, he decided he'd had enough. Today, at 78, he has a new career as unofficial—and unpaid—school doctor for several thousand Las Vegas school children.

He began by doing physical check-ups, referring children in need of attention to their family doctors. Then he helped get a school-lunch program under way.

But it soon became evident to him that his preventive program would never be fully effective until he could provide medical attention for all the children whose families couldn't afford to pay for it. So he started a public campaign for a child health center.

He enlisted Kiwanis, other civic groups, and church and charitable organizations as fund raisers. Physicians and dentists agreed to handle the children's cases for small fees, and the local hospital made beds available for them at $2 a day, with other charges in proportion.

The new program, now something over one year old, is working fine, and Las Vegans are proud of it. But Volney Cheney, well embarked on his second career in medicine, just keeps busy and looks to the future. "My plans for the children," he says, "will take years to accomplish."

clause that required only a 75 per cent loss of earnings, rather than a total loss. Since his two hours a day would have accounted for less than 25 per cent of his normal earnings, he would have had no further premium worries.

When does the suicide clause come into effect?

This question may seem a bit strange. So while you still have your eyebrows raised, let me tell you about an experience I had when starting out as an insurance underwriter many years ago.

A businessman friend was ready to take out a $50,000 life insurance policy with me. But his wife persuaded him to make the purchase from her cousin. As a sort of consolation prize, he bought a $5,000 policy from me.

I'd known this man for a number of years. He was successful and, to the best of my knowledge, happy and well adjusted. Yet, a year and a half later, when a well-publicized family scandal all but wrecked his business, he committed suicide.

I delivered a $5,000 check to the widow. But she never got the $50,000 from the policy her cousin had written. The reason: His company paid suicide claims only after the policy had been in force for two years. Mine paid after one year.

Now I'll admit that suicide cases are rare, and I don't suggest that many doctors are likely to kill themselves. Still, all else being equal, you can't lose by choosing the policy with the more liberal coverage.

If you're combining an annuity with your life insurance, does it provide a joint life income for both husband and wife?

Most policies guarantee a life income to the insured only. If the husband dies, say, eight years after annuity payments begin, the wife will receive only two more years of income. But about a third of the major companies offer in their contracts the option of a smaller monthly life income for as long as either the insured or his wife lives. This is worth looking into.

The important point to remember is that the highest premium rate does not necessarily mean the best contract; nor does the lowest premium rate mean the worst contract. It's just common sense, then, to get a policy with liberal provisions.

Pediatrician's Lament

She tells her children gruesome tales
Of what will happen here;
Then says that I'm incompetent
Because they shriek with fear.

When the Doctor Gets the Treatment

You'll resent the time loss if you get sick, but you'll learn from the experience

I always look forward to taking care of one of my fellow physicians who has fallen ill. It gives me a fine chance to study some of the more bewildering phases of the doctor-patient relationship.

Offhand, you would expect a sick doctor to be a good patient. For he should know, from his own work in medicine, what to expect.

But beneath his professional exterior, a doctor is a human being, after all, with all the ordinary human failings. The sick doctor, in fact, is apt to prove *more* cantankerous than the lay patient—simply because he knows too much.

Early in his illness, he begins to express all sorts of dissatisfactions. Why did this have to happen to him? He'd thought he was indestructible; now here he is, helpless. He worries about his practice, about economic losses resulting from his illness, about hospital expenses. And he worries about his patients—whether, for example, they'll still *be* his patients when he's back on the job.

Before long, too, he becomes an authority on hospital annoyances: The smells are terrible. The groaner in the next room won't let him sleep. The nurses at the central desk talk too loudly and ignore his light. The food is awful. The orderlies seem careless, the student nurses and internes flip.

He complains about the mechanical hospital routine and about not being allowed to smoke. And if he's in a teaching hospital, he resents being used as a guinea pig on teaching rounds.

Why must the medical students always poke *his* belly? Why, in short, is he treated just like everyone else?

The hospitalized physician behaves like the patients he used to accuse of being neurotic. He even looks forward to the same things as they.

If, for instance, the attending M.D. shows up a little later than expected, the sick doctor is sure to ask what kept him. He perks up at an encouraging grunt; he does a tailspin if told things are coming along "more slowly than I'd hoped."

And what does he want most to know? "When in hell do I get out of here?" [MORE→

By William Kaufman, M.D.

Nor is this typical patient reaction confined to doctors who are hospitalized. Not long ago, a psychiatrist came to my office for a routine check-up. All went well until I put a tourniquet on his arm.

"What are you doing?" he snapped.

"Just taking a little blood."

"That's not necessary."

I told him I thought it was, and made him lie back on the examining table. Then I noticed that his neck arteries were pulsating wildly.

"What's the matter?" I asked.

It took him a moment to answer, but at last he confessed: He was deathly afraid of needles. "That's why I went into psychiatry," he added lamely. He was still unnerved long after I had taken the blood sample.

Can Free Care Be Good?

The sick physician differs from other patients in one respect, of course: He usually doesn't have to worry about doctor bills. But he *does* worry about whether his colleagues are giving him the same quality care they give paying patients. At least, that's what was bothering a G.P. friend of mine a while back.

Recognizing the possibility that he might have a serious disease, this G.P. had consulted several of his medical friends. All of them had examined him thoroughly and found nothing wrong. But he still wasn't satisfied.

Under an assumed name, then, he made an appointment with a doctor in a distant city. Acting the part of a layman, he underwent his examination and received another clean bill of health. He paid his bill and left, finally convinced that he was in good shape.

Why did he place more faith in the findings of an out-of-town doctor than in those of close associates? He explained to me later: "After all, I *was* imposing on my friends. It seemed reasonable to suspect that their findings might have been based on superficial examinations."

Sometimes—such is the perversity of human nature—a doctor becomes embittered at the very physician who has helped him. Some years ago, for example, a friend asked me to examine a small mole that had been bothering him. The physician he'd seen had told him to forget about it; obviously, he was not expecting further reassurance from me.

Instead, I recommended surgery, and he consented. The tumor proved malignant. As a result, the operation was an extensive one and it left some noticeable scars.

This man who might today be dead is instead alive and well. Yet he refuses to speak to me, and I've heard that he openly discourages patients from consulting me.

The Scientific Method

The scientifically trained physician, then, is often no more rational and "scientific" than the layman when faced with illness. In addi-

tion, he's sometimes incredibly careless—even stupid—about what ails him. To illustrate:

We doctors are always telling patients how silly it is to put off elective surgery because of fear. We have little sympathy for the patient who demurs despite our words of wisdom. Yet this lack of sympathy, I suspect, stems mainly from our own ignorance of how it is to face such a situation. When *we* develop something wrong, we're likely to sing a different tune. [MORE→

Snowed Under every workday by some 500 requests for medical advice, Dr. Theodore Van Dellen needs three assistants to help answer his correspondence. As editor of the Chicago Tribune's "How to Keep Well" column, he got 127,301 letters last year.

What do readers ask him? Mostly: Is there a cure for this or that disease? What are my chances of recovery? But many also query him about doctors' fees and operation costs.

Only one letter in five requires a personal reply. The others are answered with printed information from Dr. Van Dellen's 300-subject file. Readers who want him to recommend a physician get a list of six local doctors. The names come from a roster that Dr. Van Dellen changes constantly, to avoid playing favorites.

I came to realize this early in my career. As I made hospital rounds in those days, I often saw two of our senior surgeons chatting together. I joined them whenever I could, eager to pick up any tidbits of knowledge. Yet, one theme kept recurring in their conversation:

'How's Your Rupture?'

"How're your piles, Harry?" one would ask.

"Not so good, Joe," Harry would reply. "Mineral oil doesn't seem to help the way it used to." Then, as though to change the subject: "How's your rupture these days?"

"Acting up again. That truss I wear—you know, it's no damn good."

"Why don't you take a few weeks off and let me fix you up?"

"Maybe I'll get around to it one of these days. When are you going to let *me* do *you*?"

At this point Harry would generally dash off, mumbling about a call he had to make. Whereupon Joe would turn to me. "Foolish, isn't he? Imagine suffering with those piles when I could fix him up like new." Having made this pronouncement, he would hitch up his truss and depart.

Is it true, I wonder, that surgeons are more afraid of surgery at the hands of other surgeons than any timid layman could possibly be? And is it equally true that you've got to be sick yourself before you can understand what sickness is like? It seems so.

I'm reminded here of a bright young surgeon I used to know, with a passion for rooting people out of bed twenty-four hours after their operations. "If I had my way, they'd walk back from the operating room" used to be one of his pet sayings.

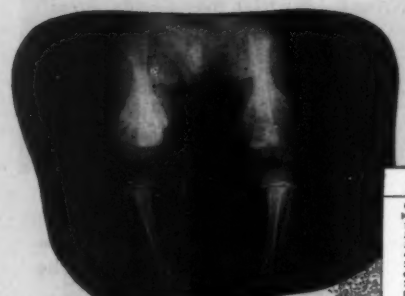
One day, he himself had to undergo surgery for acute appendicitis. But he made his surgeon promise to get him up in twenty-four hours. The operation was a success, and the patient lived. The next day, however, he didn't feel a bit like bouncing out of bed; he was learning at first hand how it feels to be operated on.

Unfortunately, his colleague was insistent: "You'll feel much better out of bed," he chided. "Anyway, I never break a promise to a friend." So the patient had to drag himself up. Thereafter, this physician was more solicitous about the comfort of others.

The Patient's Viewpoint

A proctologist of my acquaintance also developed the patient's perspective on short notice. One day I listened as he told a group of internes about a bit of remarkable surgery he had just performed. He capped his story thus: " . . . And if I hadn't done a sigmoidoscopic examination, the man would have been a goner in two years."

Apparently some of the internes seemed unimpressed; so he added: "*Everybody* should have a sigmoidoscopy. That means you." He pointed to one of the group. "And



0-11 da.	340	0	0	174	0	166	0
10-29 da.	90	1	—	41	1	49	0
1 mo.	90	0	0	48	0	51	0
2 mo.	90	2	2.2	54	2	36	0
3 mo.	80	3	4.3	31	3	46	0
4 mo.	79	2	2.5	29	1	50	1
5 mo.	73	12	16.5	32	3	46	0
6 mo.	53	13	24.5	19	1	34	0
7 mo.	36	10	18.5	22	3	32	1
8 mo.	40	5	12.5	18	1	32	1
9 mo.	30	10	26.3	13	0	28	1
10 mo.	41	5	12.2	16	0	33	1
11 mo.	40	3	7.5	12	0	28	1
12-23 mo.	177	3	—	66	1	109	1
Total	1180	69		585	39	797	48

PREVALENCE OF SCURVY

SCURVY

is more common than many think

Histological examination* of bone structure in 1300 infant post mortems revealed that scurvy occurred more than 10 times as frequently as is usually shown by clinical diagnosis. The most susceptible age is from the fifth through the eleventh month, with approximately 17% of infants exhibiting the histological signs. Over half of the children with scurvy had never received supplemental vitamin C. How easy to prevent, when Florida citrus is so rich in vitamin C content — so convenient, so economical, and so pleasant to take!

* *Bull. Johns Hopkins Hosp. 87:569, 1950.*

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you." He pointed to another. "And you."

"And when did *you* have *your* last sigmoidoscopy?" someone asked.

His mouth dropped open. "Matter of fact, I don't think I ever had one," he admitted. But taking his own advice, he picked up a phone then and there and made an appointment with a proctologist-colleague.

A week later, I asked him how he'd made out. "You know," he said, "it's quite a thing!" He described the procedure in painful detail. I sympathized with him and was about to excuse myself when he grabbed my arm.

"Bill," he said, "promise me one thing. Never use it routinely—only when there are indications!"

He had learned something from his experience; he had learned what it's really like to be a patient. And, as I see it, no doctor may rightly consider his education complete unless he has been forced to see the physician-patient relationship from the other side of the fence.

A major illness for the doctor represents more than lost time. It may actually be a real opportunity. If he survives—and if he wants to remain in medicine—his experience should make him a more tolerant, more understanding practitioner.

END

"Why, Mr. Elrod, there's every reason in the world for you to *want* to get well. Look at the international situation; it's . . . er . . . Well, look at the national situation, what with income tax and . . . er . . . er . . . Look at it from a personal angle; there's your wife and your job . . . er, well . . . let's see . . . hm-m-m . . ."

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What M.D.'s Are Wearing in the Office

You may be surprised to learn that most of them prefer uniforms to mufti

• What's the favored garb for office wear these days? To get an idea, MEDICAL ECONOMICS has sounded out more than a thousand physicians across the country. The consensus is that uniforms are preferable to business suits for general office wear—even though, as one respondent puts it, the white-coated M.D. may sometimes be taken for "an interne, a barber, or a soda jerk."

More than half the physicians surveyed say they *usually* wear office uniforms. About a sixth of them wear uniforms *occasionally*. Only a third *never* wear them.

The trend toward uniforms is marked. For every respondent who wears a uniform *less often* today than he did a decade ago, there are two who wear them *more often*.

Uniforms are most popular in the Far West, where three out of four doctors surveyed usually wear them. In New England, on the other hand, they are worn by only about half the physicians queried.

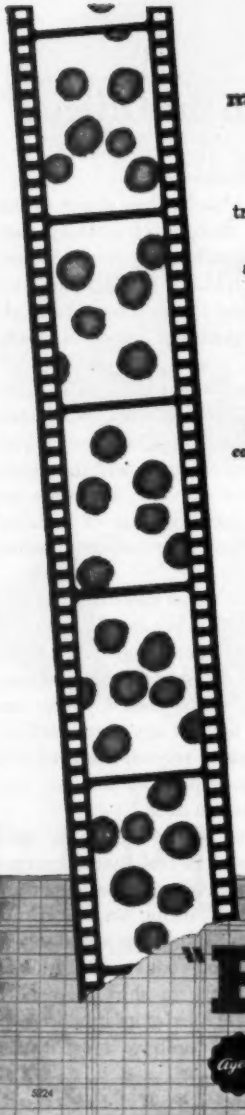
Physicians who do not wear office uniforms are vocal in their opposition. Mainly, they object to the frequent changes of clothing that the use of uniforms requires. Writes a Southern G.P.: "I dash in and out of the office all day long. I can't afford to take time out for a dozen changes."

Non-uniformed M.D.'s also claim that clinical garb tends to frighten small children and nervous adults. Several psychiatrists add that, from their point of view, uniforms are bad medicine because of patients' notions about "the man in the white coat."

One physician says he doesn't wear a uniform because he can't find a style to "camouflage my middle-age spread." A different problem, however, confronts a young surgeon: "I haven't any gray hairs yet, so I've got to rely on business suits to convince patients that my resident days are over."

A good many doctors in small towns seem to feel that donning a uniform would make patients think they were "putting on the dog." Says one: "When I'm afraid of getting my good coat stained, I take it off and work in shirt sleeves." A Maine G.P. carries informality even further. His "uniform": a sport shirt

By Wallace Croatman



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...may be needed to accelerate recovery in microcytic hypochromic anemia. This is particularly true when the anemia is the result of blood loss. In such cases, you will want to prescribe **not only iron but all the elements known to be essential for the development and maturation of red blood cells.** "Bemotinic" provides all these factors.

Each capsule contains:

Ferrous sulfate exsic. (3 gr.)	200.0 mg.
Vitamin B_{12} U.S.P. (crystalline)	10.0 mcg.
Gastric mucosa (dried)	100.0 mg.
Desiccated liver substance, N.F.	100.0 mg.
Folic acid	0.67 mg.
Thiamine HCl (B_1)	10.0 mg.
Vitamin C (ascorbic acid)	50.0 mg.

In macrocytic hyperchromic anemias, "Bemotinic" will provide additional support to specific therapy, or may be used for maintenance once remission has been achieved. In many pernicious anemia patients there is a need for iron because of a co-existent iron deficiency.

Suggested Dosage: One or 2 capsules (preferably taken after meals) three times daily or as indicated.

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and slacks, plus moccasins in summer and logging boots in winter.

Other objections to uniforms:

¶ "They remind patients of mass-production clinics."

¶ "They soil more easily than regular clothes and cost too darn much to get laundered."

¶ "Too Hollywoodish."

What's the stand taken by doctors who do wear uniforms? Primarily, that uniforms conserve their regular clothes. Also, that they look "neat and professional." Some add that the M.D. who changes clothes when he leaves the office takes less chance of spreading infection to his family than the one who wears the same suit. And a few point out that uniform costs are tax-deductible.

As might be expected, the doctors surveyed are a pretty conservative lot in the uniform styles they prefer. Nine out of ten, for example, favor white over colors; and they choose inexpensive cotton over nylon by about the same margin.

Seven out of ten would rather fumble with buttons than with other type fasteners. And although six out of ten prefer short jackets to long, six out of ten vote for long *sleeves* over short.

It's evident from all this that while the use of uniforms is increasing, there are still all shades of opinion on what a doctor should wear in his office. Unanimity among physicians is, in fact, about as unlikely in their choice of office garb as in their choice of blondes vs. brunettes as secretaries. END

Darby and Joan

• She was elderly and very much in earnest. "Doctor," she said, with a quaver in her voice, "you must examine me thoroughly."

In the course of taking her history I learned that while she was 86 years old she had no real complaints at all. I told her, therefore, that since I'm a surgeon, it would be best to refer her to a medical man who could care for her if any trouble *did* arise.

"No, Doctor," she said, "your office is near by and I can come here more easily. You must take care of me and keep me alive." Then she added: "I must at least outlive my husband."

Taken aback, I asked how old he was. She said he was 96.

"Then why is it so important that you outlive him?" I inquired.

"Well, you see, Doctor," she answered softly, "There are only the two of us left. Our children have all gone. If I die first, there will be no one to take care of him."

She got her wish. —LEROY JAY HYMAN, M.D.

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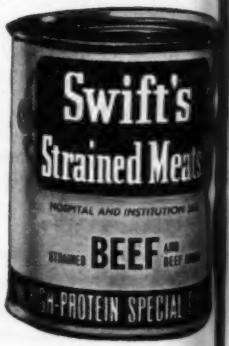

7 VARIETIES

BEEF • LAMB • PORK • VEAL • LIVER • HEART • LIVER AND BACON

All nutritional statements in this advertisement accepted by the Council on Foods and Nutrition of the American Medical Association.

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Doctors recommend–

Swift's Strained Meats, just like the original Swift's Meats for Babies. They are an excellent source of biologically valuable proteins, B vitamins, and food iron —and they are low in fat content.

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Palatable Swift's Strained Meats, when they need a high-protein, soft diet—such as in geriatrics feeding, ulcer management, pre- and post-operative care.

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Swift's Strained Meats in hospitals, nursing or convalescent homes, and other institutions, because these meats are so convenient to serve. The individual particles are strained fine enough even for tube feeding!

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With Swift's Strained Meats, because these meats are expertly prepared and ready to serve. And the new economical *12-ounce* size saves time, and cuts labor costs even further in the special diet kitchen.

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☐ *Send me free booklet on uses and costs of Swift's Strained Meats in the new 12-ounce institutional size.*

☐ *Your representative may call on me.*

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*City*_____ *Zone*____ *State*_____

Cardalin

tablets

For the first time, Cardalin permits high oral doses of aminophylline—*5 GRAIN TABLETS*—one or two 5 grain tablets 3 to 4 times daily may be administered as required. Gastric irritation and intolerance to the drug are virtually eliminated by means of a new use of anti-nausea factors which block irritant impulses at their source.

Cardalin provides full therapeutic utilization of aminophylline by the oral route of administration, as demonstrated by recent, extensive clinical investigations.

You Can Deduct for Entertainment

Here's a new statement on a national tax policy that's been a puzzle to doctors

"The cost of entertainment is a type of expense that has given doctors and other professional men considerable trouble in connection with their Federal income tax returns . . ." So says E. I. McLarney, Deputy Commissioner of Internal Revenue. And a good many doctors, to judge from their letters to MEDICAL ECONOMICS, would fervently agree.

What *are* these troubles? A California physician, for example, tells us that his tax collector refuses to allow *any* entertainment deductions. From Georgia, a surgeon writes that his occasional gifts to patients have invariably been challenged. An Alabama specialist tells of having been warned by his collector that his return would be automatically double-checked whenever it contained deductions for professional entertainment. A Michigan physician complains that such deductions are allowed for some colleagues, but not for him.

In view of these apparently contradictory local rulings, MEDICAL ECONOMICS has asked Deputy Commissioner McLarney for a clarification of the policy of the Bureau of Internal Revenue. Here, briefly, is what we've learned:

First: Local collectors cannot categorically deny deductions for entertainment on physicians' tax returns.

Says McLarney: "This Bureau recognizes professional entertainment as a legitimate deductible expense under section 23 (a) (1) (A) of the Internal Revenue Code, which allows 'ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business.' " This, he adds, holds good for physicians *in all parts of the country.*

Why, then, do doctors get into trouble over this item? Mainly, says the deputy commissioner, because of inadequate proof for their claims. It is, he concedes, often inconvenient for a physician to keep records of such expenditures. But records must be kept; and the doctor must be prepared to prove that he spent the money for professional purposes "and not for purely personal or friendly enjoyment."

As an example of a doctor who didn't have such evidence, McLar-

By James C. Fuller

ney cites a recent case in the U.S. Tax Court. This physician, an obstetrician, testified that he gave wedding presents to patients so they would "keep him in mind," and that he entertained colleagues and hospital staff-members with an eye toward possible referrals.

Unfortunately, he hadn't itemized on his tax return the amounts he'd spent for gifts, flowers, and various forms of entertainment. Nor had he indicated the specific professional purpose of each of these. Moreover, he couldn't even present proof of having actually spent the contested amounts. As a result, the court disallowed his deductions.

Explain Yourself

How can doctors make sure that their deductions won't be disallowed? According to McLarney, taxpayers who have had their claims upheld in court have fulfilled two conditions:

1. They have named or described the clients they have entertained.

2. They have stated the nature of the business benefits "reasonably to be expected" from these persons. Reasonable expectation, adds McLarney, is not evidenced by "a vague statement that the doctor *hoped* to derive some business from an expenditure."

It's up to the doctor, in other words, "to show that the entertainment is clearly in his professional interest." Which means that the wise physician will indicate on his tax return the explicit aim—and, whenever possible, the beneficial result—of each of his various outlays for entertainment and gifts.

Otherwise, he may get an unwelcome call from the tax examiner. According to McLarney, the examiners consider "claimed deductions that are not satisfactorily explained" good reason for pulling out a return for further checking.

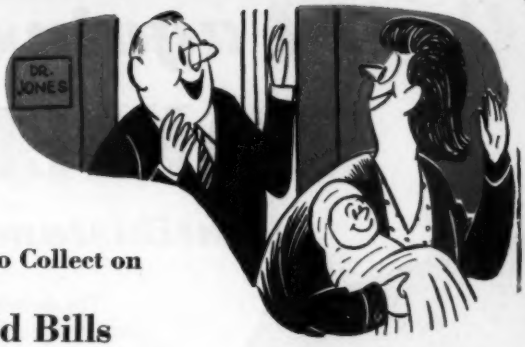
Are They After You?

Some doctors who have been tagged in this screening process suspect that M.D. returns are often a special target of the tax auditors. We asked about that, too.

Suppose a doctor's deduction for entertainment exceeds an arbitrary amount, say $200. Will his return then be singled out automatically for auditing, because he *is* a doctor? The deputy commissioner's answer is "No. All field examinations of income tax returns are made under uniform rules that apply to all taxpayers alike."

Local examiners, he points out, "use their judgment in selecting returns for audit." So, though they may not officially discriminate against the doctor, a careless physician may well call himself to their attention by his very carelessness.

Why? Because, says McLarney, "any deduction for entertainment purposes, if substantial in amount and *apparently unrelated to the taxpayer's profession*, would be sufficient to serve automatically as the starting point for a routine investigation."



What You Stand to Collect on

Those Unpaid Bills

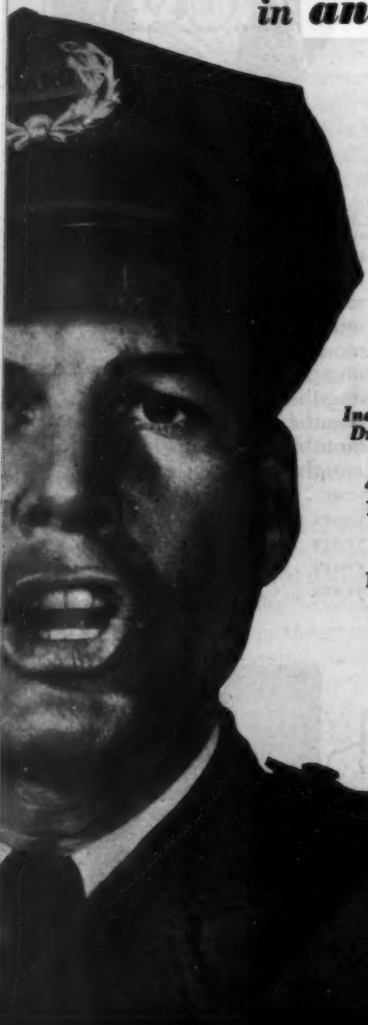
• How many cents on the dollar are you likely to collect on patients' overdue accounts? You'll get a fairly good idea from the accompanying table of collection ratios for doctors' bills, gleaned from the records of the National Association of Medical-Dental Bureaus. These figures, says the association, are as "accurate as can be developed" for the U.S. medical profession at large. But, of course, the individual M.D. can expect *his* returns to differ somewhat from the over-all averages—depending on such variables as experience, type of practice, and location. END

Age of Account	Its Value (in cents per dollar)
2 months	.90
3 months	.85
4 months	.81
5 months	.76
6 months	.71
7 months	.67
8 months	.62
9 months	.57
10 months	.53
11 months	.49
1 year	.45
2 years	.23
3 years	.15
4 years	.07
5 years	.00

Guard against

DANGERS O

in antihistamine thera



The danger of sedation from
antihistamines—particularly for
patients—has been repeatedly emph

Neohetramine affords an
degree of freedom from sedative
(full alertness has been repo
98.2% of patients tested)—combine
a high degree of therapeutic

As compared[1] with five other widely
antihistamines in tests on 781
(including 399 cases of hay

Incidence of Drowsiness		*Hay Fever Patients*
1.8%	NEOHETRAMINE	71.7%
42.9%	Antihistamine A	63.6%
13.5%	Antihistamine B	73.2%
9.2%	Antihistamine C	69.8%
6.2%	Antihistamine D	56.2%
10.1%	Antihistamine E	76.6%

1. Schwartz, E.: Ann. Allergy

NEPERA CHEMICAL CO., INC.
Pharmaceutical Manufacturers
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SEDATION

of hay fever

Available:

Tablets –25, 50, and 100 mg., in bottles of 100 and 1000.

Syrup –6.25 mg. per cc., in bottles of 1 pint.

Cream 2% – in water-miscible base, in collapsible tubes of 1 oz.

Prescribe . . .

Neohetramine®

BRAND OF THONZYLAMINE HYDROCHLORIDE

N,N-dimethyl-N'-p-methoxybenzyl-N'-(2-pyrimidyl) ethylenediamine monohydrochloride

Things you should know about the new plastic bandage

CURAD®

You can wash a CURAD
New waterproof CURAD stays on, even in soapy water.

Resists oil and grease
Plastic CURAD stays clean for days, smooth surface sheds grime.

Fits like your skin
CURAD is elastic, fits skin contours for better protection and can't ravel at edges.

Contains Furacin*-Tyrothricin
CURAD is the *only* adhesive bandage available either plain or with new Furacin-Tyrothricin medication.

Outlasts 3 cloth bandages
One CURAD outlasts 3 old-style cloth bandages—a big economy feature.

Now available in new dispenser pack
New CURAD dispenser packs of 100 open into convenient desk or wall dispensers. Choice of two bandage sizes: ¾" x 3" $1.10 per 100; 1" x 3" $1.35 per 100. Your supplier has CURAD now.

CURAD
PLASTIC BANDAGES

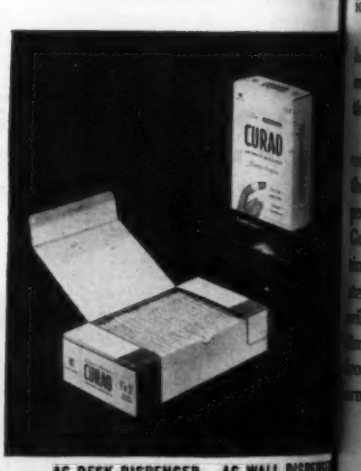
A NEW Curity PRODUCT

BAUER & BLACK
Division of The Kendall Company

*Eaton Laboratories, Inc., brand of Nitrofurazone

OLD-STYLE BANDAGE NEW CU

WASH THE BANDAGE AS YOU WASH YOUR



AS DESK DISPENSER AS WALL DISPE

A.M.A. Prescribes for Federal Health

New policy statements urge limits on Federal taxing, subsidizing, and planning

• For more than a hundred years, the stated aim of the American Medical Association has been "to promote the science and art of medicine and the betterment of public health." But today the association is branching out.

"The time has arrived," A.M.A. delegates agreed at their recent Chicago session, "when the American Medical Association should approve broad, basic governmental principles *outside* the actual field of medicine . . ."

Why this switch? Because A.M.A. health objectives "can be attained only upon the basis of a sound national economy."

One new plank in the A.M.A.'s widened platform, for example, is a thrust at "confiscatory taxation imposed by a bureaucratic Federal Government." If this trend continues, the delegates resolved, "the state and local governmental units will become impotent and will in time have to rely entirely on doles from an all-powerful Federal Government." The recommended remedy: an amendment to the U.S. Constitution limiting the Federal taxing power.

Further evidence of the A.M.A.'s new wide-angle view is a 2,500-word statement of policy presented to the delegates. It was drawn up by three trustees—Drs. Walter B. Martin, Edwin S. Hamilton, and Leonard W. Larson—to replace the association's outdated "twelve-point program." The new statement is shot through with expressions of a drastically broadened outlook.

Here, among other things, is what it has to say:

On A.M.A. aims: "It is our purpose . . . to scrutinize the many proposals for the betterment of medicine and public health [so that] they may be brought within the ability of the people to pay and without jeopardizing our national economy or undermining our constitutional guarantees."

On bills before Congress: "The administrative features of most bills . . . are objectionable. The American Medical Association is opposed to any bill carrying a Federal subsidy in the field of medicine which does not in the body of the bill define and limit the powers of the adminis-

By Alton S. Cole

presenting

BUTAZOLIDIN®

brand of phenylbutazone

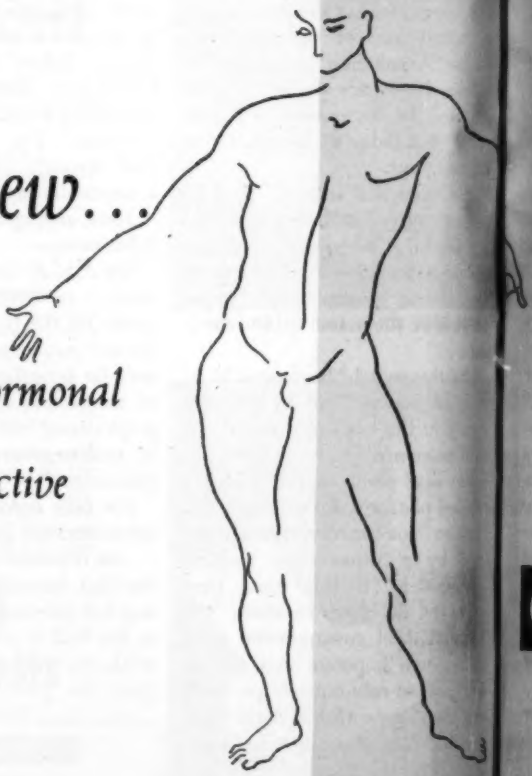
for relie

totally ***new***. . .

synthetic

non-hormonal

orally effective



ARTHRITIS *and allied disorders*

After almost four years of intensive pharmacologic and clinical research, BUTAZOLIDIN, a totally new nonsteroidal agent for the relief of arthritis and allied disorders, is now available on prescription.

The distinctive features of BUTAZOLIDIN include:

- ***Broad Therapeutic Spectrum*** **that includes virtually all forms of arthritic disorder.**
- ***Potent Therapeutic Effect*** **evident in relief of pain, accompanied frequently by decrease of spasm and swelling and increased mobility.**
- ***Prompt Action*** **manifested generally by clinical improvement in 24-48 hours.**
- ***High Tolerance*** **affording a relatively low incidence of serious side reactions.**
- ***Effectiveness by Mouth*** **in dosage of 600-800 mg. daily.**

BUTAZOLIDIN *is well within the means* **of the average patient.**

indicated in all arthritic and allied disorders

Gouty Arthritis
Rheumatoid Arthritis
Spondylitis
Osteoarthritis
Psoriatic Arthritis

For relief of pain associated with:

Fibrositis
Muscular Rheumatism
Bursitis
Osteoporosis of the Spine
Scapulo-humeral Periarthritis
Myositis
Neuralgia
Herniated Intervertebral Disc
Sciatica

In order to obtain optimal results and to avoid untoward reaction it is highly desirable for the physician to become thoroughly acquainted with the characteristics of BUTAZOLIDIN before prescribing it. Physicians are urged to read the package circular carefully or to write for the BUTAZOLIDIN brochure, which will gladly be sent on request.

Availability: **BUTAZOLIDIN (brand of phenylbutazone*) issued as sugar-coated tablets of 200 mg. and 100 mg.**

GEIGY PHARMACEUTICALS • Division of Geigy Company, Inc.
220 Church St., New York 13, N. Y.

*U. S. Pat. No. 2,843,599

trator . . . The usual procedure [at present] is to state the purpose of a bill and sketch its outline in broad and general terms. A Federal agency is then designated to administer the Act, and the head of that agency becomes the administrator. He is granted the power to make such regulations as he deems necessary . . . These loosely drawn bills leave to the judgment and discretion of the administrator extensive law-making powers. We see no profit but great danger in [this]."

On Federal subsidies: "The whole question of . . . the partition of our tax resources between the Federal, state, and local governments needs to be re-examined and re-evaluated. We are opposed to further extension of Federal subsidy except in those instances where it can be shown that in fact the security of our country would otherwise be threatened. The flow of the major fraction of our tax money into the Federal treasury and its redistribution to the several states in the form of grants or subsidies is a dangerous procedure . . . The evil becomes more apparent when we see Federal subsidies used as a club to compel the adoption by the states of certain procedures not acceptable to all of the states . . ."

On national planning: "The demand is repeatedly being made that an overall plan of medical care for the American people be formulated. Nothing could be more unwise than to attempt this, whether the plan be designed by the American Medical Association or the Federal Government. The strength of this country has come from the political autonomy of the states and localities, and the freedom of our people to experiment along various lines. In a country as vast as ours, with its diverse political beliefs, social standards, economic needs, and population density, an overall plan can only be made effective by a degree of regulation and compulsion that would crush out our initiative . . ."

These new A.M.A. statements are significant on several counts. For one thing, they give strong expression to the "states' rights" theory of government—a stand that may take the association into new areas of political controversy.

For another thing, the new A.M.A. statements represent a change of heart on at least two important medical-political problems:

¶ According to the earlier twelve-point program, "it may be necessary

for Control of Hypertension

Apresoline®

Hydrochloride
(brand of hydralazine hydrochloride)

Apresoline is a relatively safe, *single* antihypertensive drug with no serious untoward actions, providing benefits in many cases—complete control in some. It is recommended that Apresoline be used in those hypertensive patients who have not been adequately controlled by conventional regimens (diet, mild sedation, rest, etc.). The following important considerations should be of interest in general practice:

Effective in essential hypertension with fixed renal, early malignant hypertension, toxemias of pregnancy and acute glomerulonephritis.

Provides gradual and sustained reduction of blood pressure with no dangerous, abrupt fall upon administration.

Affords uniform rate of absorption and infrequent dosage adjustments.

Increases renal plasma flow in marked contrast to the decrease associated with other hypotensive drugs.

Side effects often disappear as therapy is continued or can be ameliorated with adjunctive medication.

Produces significant relaxation of cerebral vascular tone.

Complete information regarding manner of use and clinical application available on request.

Ciba

Ciba Pharmaceutical Products, Inc., Summit, New Jersey

first and **only**
topical therapy to contain
panthenol

CLINICALLY EFFECTIVE—
new studies[1,2] show that topical panthenol (analog of pantothenic acid) "favorably influenced the course of various ulcerative and pyogenic dermatoses. A majority healed and many showed various degrees of improvement." Even long standing conditions resistant to other therapy seem to respond to Panthoderm Cream which...

relieves pain and itching
promotes granulation and healing

"This preparation (Panthoderm Cream) showed clinical evidence of *epithelizing stimulation*, of an *antipruritic effect*, and of an *antibacterial effect*...in a variety of dermatoses."[1]

Varicose ulcer of ankle, large, deep, profuse foul-smelling discharge.

Healing of ulcer after treatment with Panthoderm Cream for 10 weeks.

1. **Kline, P. R., and Caldwell, A.: New York St. J. M., May 1, 1952.**
2. **Combes, F. C., and Zuckerman, R.: J. Invest. Dermat. 16:379, 1951.**

for some medical schools to accept financial aid from the Federal Government." The A.M.A. has now slammed this door, saying: "We doubt if it is possible to write an Act, subsidizing a school system, hedged about so effectively with safeguards that these cannot be eventually broken down or evaded by an astute administrator."

¶ According to the earlier twelve-point program, the A.M.A. favored "aid through the states [presumably Federal aid] to the indigent and medically indigent by the utilization of voluntary hospital and medical care plans." The A.M.A. now urges "financing medical services as far as possible by private contributions and local taxation."

As Radio Portrays the Doctor

He's neurotic and insecure, says this physician's wife—if the soap operas don't lie

● As a doctor's wife, I have long been ashamed to face my neighbors. Why? Because I know they listen to the same radio programs I do. And if they take their soap operas seriously (as who doesn't?), what in the world must be their opinion of my husband's once honorable profession?

The serials have painted doctors as an egocentric, neurotic, impractical, improbable race of men. Let's take a look at some of them:

As I write this, Dr. Jim Brent, of "The Road of Life," is being faced with expulsion from the hospital staff because of a girl's lies about his promise of marriage. Admittedly, this could happen to almost anyone—but wouldn't you think that in a small town like Dr. Brent's, people would know enough about his sterling character to scoff at any such accusation?

Poor old Jim. He's a weak man anyhow where women are concerned. This is by no means the first time that he's had trouble with them.

In "Big Sister," Big Sister's husband, John, is an irascible, irritating, egotistical, overgrown baby. He gave up private practice to enter clinic work—which was quite a gesture, considering that he planned to support the three members of his family and a car, as well as pay off a mortgage, on $2,000 a year.

In addition, John constantly fights with his wife over imagined slights to his self-esteem. As if *his* peculiar

By Elaine Diamond

LACTUM

MEAD'S LIQUID FORMULA MADE FROM WHOLE MILK AND DEXTRI-MALTOSE

NUTRITIONAL SOUNDNESS

Lactum's milk protein content (16% of calories) provides generously for sound tissue development. And Dextri-Maltose supplements the lactose of the milk, so that energy needs may be fully met, and protein "spared" for its essential functions.

For more than 4 decades, milk and Dextri-Maltose formulas with the approximate proportions of Lactum have been used in infant feeding with consistent clinical success.

CONVENIENCE

Mothers appreciate the time-saving convenience of Lactum. And the simplicity of the 1:1 dilution assures accurate measurement.

Simply add 1 part Lactum...

to 1 part water...

for a formula supplying 20 calories per fluid ounce

Lactum is ideal also for supplementary and complementary feedings.

MEAD JOHNSON & COMPANY
EVANSVILLE 21, IND., U. S. A.

MEAD'S

ities weren't enough, also present in the story is another M.D. even more insecure and neurotic than John. They quarrel whenever they meet.

There used to be a very fine old-style country doctor in "Big Sister," but he hasn't appeared in years. Apparently he wasn't neurotic enough to get by.

Dr. Jeff, in "Hilltop House," has a paranoid wife, whom he recently had institutionalized. However, he cannot accept her perhaps understandable dislike of him as a symptom of her condition. Instead, he takes it very much to heart—and does his blundering best to undermine her treatment.

In "Young Widder Brown," Dr. [illegible] has continual trouble with [illegible]rsonal affairs. For years, the [illegible] fellow was engaged to Young [illegible]der Brown, but she could never marry him because her children objected to him as a father. (Out of the mouths of babes?)

The most complete failure among these radio doctors, though, appears in "The Story of Nora Drake," a nurse. His name is Ken Martinson, and he's a drunken bum who lives off his wife's fortune; he can't convince her of his love for her—or anyone else of his medical qualifications.

They're All Failures

Another character in the same "opera" is Robert Sargent, a psychiatrist who ought to have his head examined. After consultation with my husband, I would recommend either a long course of shock treatments for him, or a prefrontal lobotomy.

Insecurity seems to be the number-one occupational disease of the profession, according to these serials. It's no wonder so few of us doctors' wives can afford television sets. It would be nice to have one, though. It would be fine to learn the *truth* about the profession from all those omniscient young men in white jackets who read their commercials with such professional authority. END

Love's Emergency

● Slamming down the telephone receiver, I rushed to the hall closet for my kit.

"What's up?" asked my teen-age daughter Joan, ducking out of the way of her hen-medic mother.

"Emergency," I replied, heading toward the front door. "A man by the name of Johnson—says he'll die if he doesn't see me right away."

"Hold on, Mom," said Joan, an impish look on her face. "I think that call was for *me*." —M.D., WISCONSIN

Letters to a Doctor's Secretary

Case histories—when and how the office aide should type and file them away

By Anna Davis Hunt

• Dear Mary:

Whenever I write you a letter, I realize once again how much more complex your work is than mine was when I started with Dr. Barrie sixteen years ago. For example, in those early days we could *remember* many of the details about his patients. But as his practice grew, it became increasingly necessary to have well-organized records. Today, I'm sure, you couldn't do without them.

Some physicians find printed forms suitable for history taking. Others—Dr. Barrie among them—prefer a well-typed history on plain paper. There is no crowding of data into small space, no leaving out of pertinent information because of lack of room, no hard-to-decipher condensation. Everything is typed out smoothly and clearly—evenly spaced, clean-cut.

Let's suppose Dr. Barrie has dictated a complete history of a new patient and you are ready to type it. Your first sheet, for permanent filing, is a good grade of lightweight bond. This will look attractive and stand up through the years. Your second sheet, or carbon copy, will be plain, white, inexpensive typewriter paper.

I have made up a sample history for you to follow (see facing page). If you consult it from time to time, you'll see exactly what I mean by the following instructions.

Set your margins for one inch on each side. Down an inch from the top of the page, on the left side, type the patient's full name. Put the surname first, then the Christian name, then the given name of husband or wife in parentheses. (If the patient is a child, write the name of his parent or guardian here.)

Next, type the residence address and phone number and, under that,

---

**These letters were published originally as a series in* MEDICAL ECONOMICS, *signed with the nom de plume Myrna Chase. In response to many requests, they are now being reprinted in revised and updated form. The complete current series, of which the present letter is the tenth, will also be made available in a portfolio.*

Doe, Mrs. Mary (John)
1322 Linwood Ave., FI 1363
727 W. Salem St., ME 1141

Aug. 15, 1952
Ref: Dr. A.B. Smith,
ME 1688

Age 60. Housewife.

COMPLAINTS — (1) Generalized abdominal pain occasionally for past five years, growing much more frequent of late. A "dull sick feeling," not localized. Lately this has occurred within one half hour after eating, and lasts from one to two hours. Frequently the pain radiates to the back.
(2) Chronic constipation. (3) Loss of weight, due to lack of appetite.

PERSONAL HISTORY — Scarlet fever and diphtheria as a child. Tonsillectomy at 20. Pneumonia at 40. No other illnesses. Deliveries normal. Menopause at 49; no complications. Felt nervous and depressed for some months after marriage of youngest child.

FAMILY HISTORY — Husband L. & W. 3 Grown children, L. & W. Father D. 65 Ca. Mother D. 70 pneumonia.

EXAMINATION — Head and neck: No headaches. Vision corrected by glasses. Infrequent head colds. No sore throats. Teeth well cared for. No swellings in neck. Hearing normal. Chest: Symmetrical in shape and movements. Well clothed. Lungs clear to percussion and auscultation. Heart sounds regular and without murmurs. B.P. 150/90. Pelvis: Normal. Abdomen: Very tender in mid-epigastrium on deep palpation. Definite tenderness over the gallbladder. Liver not felt.

IMPRESSIONS — Cholecystitis. G-I series and gallbladder dye requested. 8/20/52: G-I series negative. Roentgen examination of the gallbladder, even after forty hours' concentration, fails to reveal a definite gallbladder shadow. There are some shadows very suspicious of calculus formation. (WB/C)

DIAGNOSIS — 8/20/52: Chronic cholecystitis with cholelithiasis. (WB/C)

ADVICE — 8/21/52: Cholecystectomy. (WB/C)

the business address and phone number of the family breadwinner.

On the right side go the date and the name of the person who referred the patient. If the referring person is a doctor, add his telephone number.

You may ask why all this has to be placed here when you already have it on the financial record card. The answer is: for Dr. Barrie's convenience while interviewing the patient. He can telephone the referring doctor, for example, without hav-

ing to ask you for his name and number.

The history proper begins four spaces below the identifying data. This is where, to start with, you type the patient's age and occupation.

Next, double space and, at the left, type your first heading, COMPLAINTS, in capital letters. Continue with single-spaced lines leaving the word COMPLAINTS set off by white space, as illustrated. If there are several complaints, list them numerically and underline the key words.

The second heading in capitals is PERSONAL HISTORY. Under this comes the patient's statement of all his past physical ills. You may ask why HISTORY doesn't come before COMPLAINTS, as it certainly ranks first in point of time. The answer is that the complaint for which the patient consults the doctor is the highlight of the record and should be emphasized promptly.

Next comes FAMILY HISTORY. Abbreviate here as much as possible. M. stands for married, L. & W. for living and well, D. for dead, Ca. for cancer, etc.

The third heading is EXAMINATION; the fourth, IMPRESSIONS. Subheadings under EXAMINATION should be underlined.

This ends the case history as developed at the patient's first visit. At the time of further visits, you'll be expected to type (as shown on the history form illustrated) the results of any laboratory examinations, the doctor's further impressions, his final diagnosis, and his recommendations.

If an operation is performed, the hospital will send you a copy of the operative record and progress notes to be filed with the patient's history. Your own notes will continue from there. Even a telephone conversation that has any bearing on the case is recorded, in essence, and the date shown.

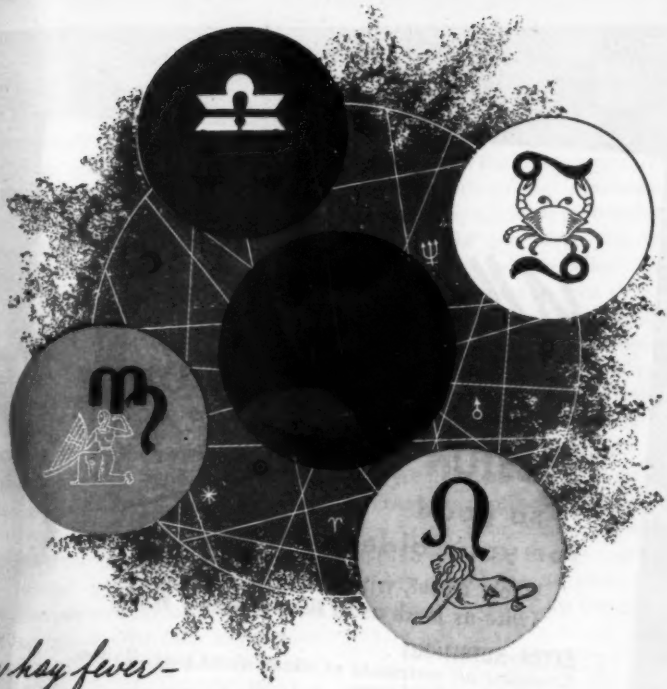
Dr. Barrie records the results of house calls on small printed slips. These provide space for noting symptoms and treatment, as well as charges and payments. The clinical material is transcribed later onto the patient's history; the financial data go into the daily record book and onto the patient's financial card (which I'll describe in another letter).

You can readily see how all this material builds into a full, chronological history of the case. If you develop it systematically, the record should always be easy to read. It will contain no extraneous matter, yet omit nothing essential.

Orderly Arrangement

Clip together the several pages of this record and number them. Build them up from the bottom, keeping the *last* page on *top*. If this seems illogical, just reflect that what the doctor told the patient on her last visit should be uppermost in his mind as he faces her today.

In the same way, reports from laboratories or other doctors are clipped together in the order in



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MEDICAMENTA VERA

Parke, Davis + Company

which they arrive, last on top. Letters from the patient, and the answers, are handled in the same way. Use small, tight-fitting clips that won't catch in other papers.

When you add notes to the record later, date each one and follow it with the initials of the dictator and the transcriber. It's fun, if the doctor guffaws over some glaring error in an old record, to be able (I hope) to point to the initials and say smugly: "That must have happened while I was on vacation."

Don't stint on typewriter ribbons. Replace them often, and keep the type clean. If you must erase, erase thoroughly and cleanly, and correct the carbon copy at the same time, leaving no smudges.

Whether the history is important or trivial, you invariably make a carbon copy on white paper. Often a carbon is needed later for the hospital or the referring doctor, and an available copy (with Dr. Barrie's name and address typed at the top) will save you a lot of time.

For the same reason, the laboratories that do your work have a standing order to send you all reports in duplicate. Yellow second sheets are used for carbon copies of everything else, such as letters, to distinguish them more readily from the history sheets.

I hope I have made clear to you how to type a case history. Now let's take a brief look at another question: When is such a record needed?

The answer is: whenever the doctor has seen a patient—any patient. We *expect* to keep full records of serious cases, but there must also be a record of every other case, no matter how inconsequential.

Make sure that the doctor dictates his findings and conclusions about any *consultation* on which he is called. For one thing, this will save you much grief in collecting.

The patient who is seen in consultation may not pass through your office and may never see the doctor again. People sometimes resist paying consultation fees; so it's well to be able to talk intelligently on the subject if the bill is protested.

Often a patient tells his story and is referred to another doctor without even being examined or charged, since he obviously doesn't need Dr. Barrie's services as a surgeon. Even so, a brief record of his complaints

"The doctor isn't in right now. But if you'd care to leave a symptom . . ."

CROSS ACTION FIRE

in infected burns

"Combiotic will control infection . . . "

Eisenstodt, L. W.: J. M. Soc. New Jersey *49*:64 (Feb.) 19[illegible]

in peritonitis or its prevention

"Mixtures of penicillin with streptomycin . . . have become popular . . . "

Rhoads, P. S.: Gen. Practitioner *5*:67 (Feb.) 19[illegible]

in contaminated wounds

"All patients . . . receive . . . penicillin and streptomycin . . . "

Keefer, C. S.: Postgrad. Med. *9*:101 (Feb.) 19[illegible]

Combiotic

. . . for the synergistic antibacterial effect of penicillin combined with dihydrostreptomycin

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1 Gram Formula
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ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC., *Brooklyn 6, N. Y.*

should be filed, with a note showing to whom he was referred.

Later, if a written report arrives from that doctor, you'll know what it's all about. Should the patient develop a surgical condition in the future, or refer a friend to Dr. Barrie, or write him a letter, you won't have to wonder who he is; you'll know.

Having everything down in black and white is the only safe, efficient system. I stress this because you'll find that Dr. Barrie himself often won't want to bother dictating notes on a seemingly unimportant case; and it's up to you to insist.

Now we come to a question of vital importance: After you've typed the histories, where should you put them for safekeeping and ready access?

Near your desk are several steel filing cabinets with locks. The first cabinet contains small drawers for financial record cards and an alphabetical card index. Each of the other cabinets contains large drawers in which are filed the case-history folders.

The folders are of lightweight cardboard. Each has an upstanding tab on which is written a file number. The cases are filed in numerical sequence. Each patient's name and number are written on a 3" x 5" card and filed alphabetically in the card-index drawer.

Filing the histories in numerical sequence keeps recent records together in the most accessible place. When the active files are filled up, older records can be removed and stored away without disturbing the sequence; yet they can be readily found if needed, since the alphabetical card index remains intact. Should a very old record become active again, it can be given a new number and replaced in the active files.

Filing need take only a few moments a day if you do it the easy way. All day long, you have been placing reports, letters from patients, carbon copies of answers, operative records, typed histories, etc. in a filing basket. If you remember the second letter I wrote you (on blueprinting your day), you recall that the time to file this material is in the morning, immediately after finishing your typing. *Don't* try to do it piecemeal throughout the day.

When the proper moment arrives, place the basket on your desk and sort its contents into two piles: first, histories and records of *new* patients; second, papers relating to *old* patients who already have folders and file numbers.

If your last filed history is, say, No. 4525, take as many blank folders as you need, and number the first one 4526. Count out the same number of plain white filing cards for the alphabetical card index.

If the first new history you have to file is Mrs. Mary Doe's, write her name on the left-hand side of an index card and her file number, in this case 4526, on the right. Insert the history in its already numbered folder, and lay card and folder side

by side, face down, on the desk in front of you. Continue this until all new histories are provided for.

In writing the names on these filing cards, follow exactly the same form as on the history. Be consistent, and there'll be less likelihood of confusion or needless searches later. Nine times out of ten, when a doctor's aide complains of overwork, it's because she does things the hard way.

Now you are ready to insert the stack of folders in the filing cabinet. When this is done, file the name (index) cards alphabetically in their proper drawer.

Next comes the pile of papers to be filed with older records. Look up the file number for each name in the alphabetical card index and jot it down in the extreme upper right hand corner of the correspondence document. When all are thus numbered, you can file them in the twinkling of an eye.

There will remain a small residue of personal letters or business letters that have no bearing on patients. These are kept in a separate alphabetical file in the deep, lower right hand drawer of Dr. Barrie's desk.

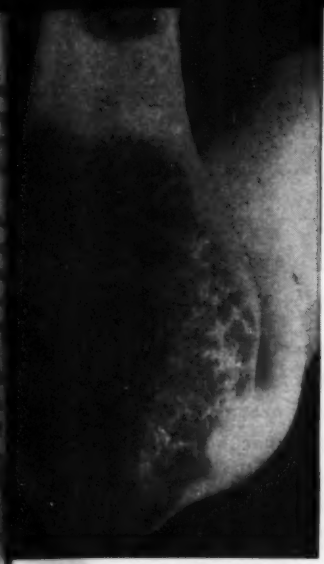
There is still another class of [illegible] with which we have to deal—the [illegible] of financial record cards. But I'll tell you about that in a later letter on the doctor's bookkeeping system.

If everything isn't perfectly clear to you so far, don't hesitate to deluge me with questions.

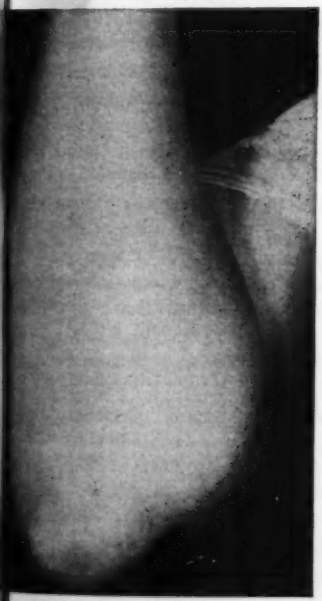
Methodically yours,

Myrna [illegible]

"I have the same symptoms myself. Get this prescription filled and let me know if it helps."



Before Use of Riasol



After Use of Riasol

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deep action

Cosmetics have their place for many superficial skin blemishes. But in psoriasis the cutaneous lesions are located in the deeper layers of the epidermis, and deep therapeutic action is required.

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Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

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RIASOL FOR PSORIASIS

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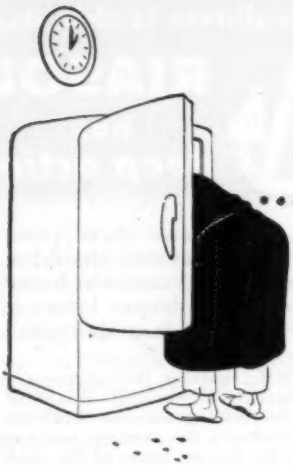

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"Patients who have been gaining excessively but are on reduced caloric intake will tell you that they are not eating excessively; that there is something wrong with them because they gain weight. Obviously they are cheating, consciously or unconsciously. One cannot gain weight on air and water."[1]

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1. Dieckmann, W. J.; Turner, D. F.; Meiller, E. J.; Straube, M. T.; Grossnickle, K. B.; Pottinger, R. E.; Hill, A. J.; Savage, L. J.; Forman, J. B.; Priddle, H. D.; Beckette, E. S.; Schumacher, E. M.: Diet Studies in Pregnant Patients. Obst. & Gynec. Surv. 3:731 (Oct.) 1948. p. 742.

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The Doctors Break Their Silence

Is medicine running a 'moral racket,' as charged by Philip Wylie? The answer from most M.D.'s: a resounding 'No'

● SIRS: I'm rather surprised that your good publication should print the ill-tempered, inaccurate, and juvenile piece by Philip Wylie, "The Doctors' Conspiracy of Silence."

It's really pretty sad. It consists of a rather junky collection of reports, rumors, ideas, and views of the author. For reasons known only to him, he combines medicine, osteopathy, chiropractic, and naturopathy all in one bundle. Mr. Wylie's outstanding contribution is to reveal his own appalling ignorance.

His conclusion that medicine needs a "Federal policing board" leaves one rather well chilled, even in cool Colorado. Would he perhaps like to see Oscar Ewing head that board? In these times, when it's difficult to name even one Federal agency that does a forthright, honest job, I'm sure we can bumble along without any more of them.

Wylie overlooks such physician-sponsored projects as the boards of supervisors [grievance committees] that now exist in some thirty-nine states. He makes no allusion to the rapidity with which hospitals and medical staffs have been eliminating past mistakes, nor to the many other progressive steps taken by medicine and its allied professions.

Surely America's health record indicates that somehow or other we have had pretty good medical care. Even Philip Wylie admits that most individual doctors do a fine job. But he seems determined to smear the profession collectively because of a few wrongdoers.

Medicine is not above criticism, and I know that most doctors welcome constructive suggestions. Fortunately for them, their good works and the high public esteem in which they are held will enable them to manage *without* a Federal policing board. [MORE→

**In a recent issue of* MEDICAL ECONOMICS, *Philip Wylie charged doctors with "a conspiracy of silence" concerning their colleagues' malpractice and urged the creation of a Federal policing board to hunt down offenders. A few of our readers apparently agree with him; many more seem to disagree. We here print excerpts from some of their letters.*

I suggest that Mr. Wylie consult one of them about his indigestion.

Evan A. Edwards
Public Relations Director
Colorado State Medical Society
Denver, Col.

• • •

SINS: Philip Wylie's father was at least partly to blame for his wife's death from postpartum hemorrhage. He could have taken her to a hospital or called in another doctor. I would remind the author, however, that some women die in this way despite every modern aid.

When the author himself had appendicitis, who called in the osteopath who attended him? Whoever did so must share the responsibility for what followed.

There is no defense for the abortionist described by Wylie; but even *he* had to have a criminal partner—the patient. It's not easy to get evidence to convict these men, b every year some of them *are* con victed and their licenses taken awa

No one in his senses would den that doctors, being human, ar sometimes guilty of sins of omissio and commission.

Does the author believe th writers as a class are any more mor or ethical than physicians? Woul he deny that pens are for hire? know that he is familiar with th admonition to "first cast out th beam out of thine own eye," and suggest that he devote some of h time and ability to cleaning up th literary as well as the medical st bles.

Frank Riggall, M.D.
Prairie Grove, Ark.

• • •

SINS: It is difficult to discredit a leg itimate practitioner unless his mi deeds are flagrant and the evide is incontrovertible. Who can dist guish an honest mistake from del berate wrongdoing?

I have seen brilliant results fro treatments decried in medical schoo as amounting to criminal malpra tice. In the March, 1952, issue o the American Journal of Ophthal mology there are two articles advo cating diametrically opposite trea ments for retrolental fibroplasia. Which of these is "right," which "wrong"? Perhaps the medical pro fession is justified in following, a times, the precept, "Judge not, tha ye be not judged."

To say that the profession does nothing about its imperfections is a

"That's Davis, the OB man."

gross misstatement. Don't tell me Wylie hasn't heard of medical society grievance committees, restriction of hospital privileges, clinico-pathological conferences, etc.

But nothing is, or ever can be, perfect. Have patience, Mr. Wylie: Quackery, ignorance, selfishness, brutality, and incompetence will *all* be corrected—in Utopia.

T. W. Dasler, M.D.
Eau Claire, Wis.

• • •

SIRS: Naturally, doctors have heard rumors of the ugly deeds performed by some of their colleagues; and they have their suspicions about more of them. But doctors must be governed, like everyone else, by the rules of evidence. If evidence is difficult to obtain, the individual physician can only exert moral suasion when and where it will do the most good. But if evidence is forthcoming, appropriate action is generally taken, as the official records of our medical societies show.

Many of the tragic results that Philip Wylie attributes to criminal negligence are really due to isolated errors of judgment. Such errors would not occur if doctors had the superhuman powers attributed to them by writers' pens; but occur

Orientation luncheons of the District of Columbia medical society give new members a chance to get briefed informally on their organization's services, activities, and history. Above, President Frank D. Costenbader (left) and Theodore Wiprud, executive secretary (right), discuss medical affairs with three neophytes (Drs. Charles E. Fierst, James B. Bain, and Robert Day). Young doctors also take the opportunity to get acquainted with each other. Not all new members are necessarily young. At the

they will as long as medicine is practiced, in all good faith, by human beings.

The doctors understand Wylie's cry, and sympathize with it. But they have been working faithfully—within the profession—to reduce the evils about which he complains. And they will continue to do so, with heads bloody from pen scratches but unbowed.

Cecil Riggall, M.D.
Prairie Grove, Ark.

* * *

SUNS: We Americans seem to have entered into an era of free-for-all investigations. Everybody's doing it; either you're investigating somebody else, or somebody else is investigating you. So now, according to Philip Wylie, it's medicine's turn.

But why only medicine? What about the corruption among other groups—real estate brokers, say, or automobile men? Dentists and lawyers must also have something to hide; for wherever a number of men band together for professional reasons, you'll probably find a "conspiracy of silence."

Wylie may say that doctors differ from the rest because they deal with human lives. But aren't automobile manufacturers dealing with lives

far right, for example, is Dr. Louis Schwartz, who, not long after retiring from the U.S. Public Health Service, took up active practice as a dermatological consultant at the age of 68; he's been a member of the society for just ten months. Like Dr. Schwartz, many seasoned practitioners in the Washington area find the orientation program both helpful and interesting. Whether they're new members or old, such physicians are turning out with increasing frequency for the monthly luncheons. Added attraction: The society picks up the tab.

The elastic stocking prescription you can be sure she'll have filled

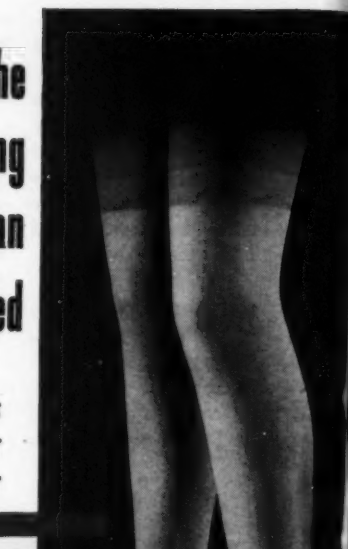
New NYLON elastic stockings from BAUER & BLACK flatter the leg and will not discolor

Female patients sometimes judge the medicine worse than the malady when you prescribe elastic stockings. But new *nylon* elastic stockings from Bauer & Black are designed to overcome their objections. Here is therapeutically correct support for surface varicose veins in beautifully fashioned elastic hosiery.

Bauer & Black elastic nylons are far less conspicuous, cooler for summer, smoother fitting—and come in a light, fashionable shade. They're easier to wash, wear longer and won't discolor. Toes are open style for foot freedom and comfort.

Most important, a fashioned leg of two-way-stretch elastic provides the firm, healthful support you want patients to have.

More women choose Bauer & Black than any other elastic stocking. More doctors prescribe them by name.



Which leg has the elastic stocking?
This photo demonstrates how truly inconspicuous the new Bauer & Black elastic nylons are. Only one leg wears an elastic stocking beneath the overstocking. It's the left—could you tell?

BAUER & BLACK

ELASTIC STOCKINGS

Division of The Kendall Company
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too? Their product is the cause of a startling number of deaths every year.

Philip Wylie has had two bitter experiences at the hands of medical men. Would he, then, be writing about the automobile industry if he knew of casualties due to faulty mechanisms in his or a friend's car?

A. F. Castro, M.D.
Washington, D.C.

• • •

SIRS: The American people love to be humbugged, particularly when they're ill. Not too many years back, doctors prescribed various evil-smelling potions, charms, and bleeding for their patients. The patients loved the humbuggery then; they still love it, and they insist on having it.

The type of thing Mr. Wylie describes has never occurred, to my knowledge, in any hospital where I have worked. In reputable institutions, each man's work is under the scrutiny of his colleagues, and a case that has gone badly is discussed at the monthly staff meeting. Poor work doesn't thrive in such an atmosphere. The charlatan and the quack can't stand the heat, and the incompetent physician avoids the light.

But the medical profession (which alone can distinguish between what is bad and what *looks* bad) has been denied the privilege of disciplining its membership by direct action. When the out-and-out medical faker is haled into court, can he be convicted? No. He can bring in a hundred witnesses to testify to the success of his humbuggery, and the jurors bring in a verdict of "not guilty."

Chas. E. McArthur, M.D.
Olympia, Wash.

• • •

SIRS: When I read Philip Wylie's article, I said to myself, "Philip, you don't know the half of it!"

I once had an assistant who turned out to be a profoundly paranoid schizophrenic. When he decided to set up his own practice, I was so happy to get rid of him that I didn't begrudge his taking enough instruments, records, and patients for a good start. But then I learned he was causing injury (and even death) to patients I had known, and my conscience got to work.

I collected irrefutable documentary evidence of his inability to practice medicine and presented it to county medical society officers and legal authorities. They told me they were powerless, since in this

"When you leave, sir, would you mind using the back door?"

state there is no law to protect the public against the ministrations of an insane doctor.

The only way I could stop him, they said, was to initiate legal action to have him pronounced insane—and in so doing run the risk of a countersuit, or even murder.

Thus a mad and dangerous man is today practicing medicine without restraint, maiming and killing as surely—and twice as subtly—as any Borgia. What's more, that man is a member in good standing of his county and state medical societies and of the A.M.A.

Name Withheld by Request

* * *

SIRS: Wylie's article is the best of its kind I've ever read.

Too many doctors are performing major operations with no further training than what they received [in] school. Responsible for this is [the] *ban on fee splitting.*

When the general practitione[r] could refer his surgical work and g[et] some part of the fee, all went we[ll]. Now, however, economic necessi[ty] compels him to do his own surger[y] whether he's competent or not.

Years ago we had surgeons w[ho] did nothing but surgery; now o[ur] doctors are forced to be jacks of [all] trades and masters of none. Ma[ny] hospitals, too, take on X-ray a[nd] technical work without personn[el] properly trained to handle these p[ro]cedures. The sad thing is that [the] public doesn't know the difference. It believes that any doctor or a[ny] hospital is as good as any other.

Arthur G. Benson, M.D.
La Crosse, Wis.

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"Certainly carrots will strengthen your eyesight. You never saw a rabbit wearing glasses, did you?"

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Your local Westinghouse X-ray office always has a plentiful supply of all leading brands in stock. Ordering from Westinghouse is your guarantee of fresh materials, delivered as fast as needed.

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no need to fight both allergy and **drowsiness...**

The allergic patient is miserable enough without having to risk the discomfort—and hazards—of drowsiness. When patients take Thephorin, a *different* antihistamine, they usually obtain gratifying relief and remain wide awake. Clinical studies show that four out of five hay fever sufferers obtain relief with Thephorin; yet drowsiness occurs in less than 3 percent of patients. Thephorin is particularly valuable for motorists, machine operators and other patients who must be alert. Available in 25-mg tablets and as an anise-flavored syrup, containing 10 mg per teaspoonful.

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Thephorin®

(brand of phenindamine—2-methyl-9-phenyl-2,3,4,9-tetrahydro-1-pyridindene hydrogen tartrate)

'Roche'

He Moved to the Country

[CONTINUED FROM 93]

roundings provide a more wholesome and homelike atmosphere in which to bring up a family. Parents know their children's friends, and are closer to their activities.

¶ Despite night calls and casual impositions, the doctor has more time for his family. In places like Philip, with field and stream almost at his doorstep, he can snatch at least some hours of recreation.

"There's a sense of belonging, of being an integral part of things, that couldn't exist in the city," he adds. "We're still 'on trial' with some of the long-established families, but most of our neighbors have accepted us whole-heartedly."

If the new hospital is not forthcoming, Kaisch intends to look for the intangible rewards he has found in Philip—*plus* better practice facilities—in another small town. In some ways, a slightly larger place, with one other doctor, would suit him; or possibly an association with another man in a clinic set-up.

"Another doctor would ease the everlasting strain," he points out. "During my two years alone, I've often wished I could talk over my medical problems with a colleague."

If you're a city doctor bewitched by the rural dream, you can avoid disillusionment by looking carefully before you leap, says Kaisch: "Don't be naive about the cheerful assurances of civic leaders charged with the job of finding a doctor. Make sure their town is the sort of place you and your family will want to live in for a long time.

"Check all the statistics to estimate how well the area can support a practice. Try to find out why other doctors didn't stay. Don't expect that everyone will be as interested as you in providing facilities; proceed with caution when an adequate hospital and office aren't already in existence or definitely on order. Steel yourself to be tolerant of such small-town foibles as some people's preoccupation with other people's business, and the tendency to forget that doctors need rest.

"In the final analysis, I suppose, fitting into rural life is mostly a matter of temperament. For the right man, the very real drawbacks can be heavily outweighed by equally real rewards." END

"On *my* salary, you're expecting *wonder* drugs?"

Yardsticks for a Community Hospital

[CONTINUED FROM 79]

According to one accepted yardstick, hospital revenue should finance 89 per cent of operating costs. So your 125-bed hospital should plan to raise an extra $67,000 annually through donations and grants.

Staffing

Perhaps the hardest element to estimate during the early stages of hospital planning is the available supply of medical and other hospital personnel. M.D.'s are scarce in many areas of the country—especially rural areas. Nurses and technicians are scarce everywhere. Obviously, there's no point in building a hospital if you can't adequately staff it.

Where doctors divide their time between private practice and hospital work, the Public Health Service figures that at least one general practitioner is needed for every 1,200 people. To assure adequate hospital staffing for a population of 60,000, then, the community needs forty-two G.P's.

Naturally, it needs specialists too: the P.H.S. estimates one surgeon for every fifty beds, one EENT man for every 100 beds, and an internist, obstetrician, and pediatrician for every 150 beds.

There's a similar "table of organization" for the non-medical staff. For every 100 patients, P.H.S. studies show that a well-run general hospital needs from 140 to 190 employes—eighty to 105 nurses; some thirty X-ray, laboratory, and dietary experts; and about thirty-five clerks and housekeepers.

Most hospital experts advise choosing the administrator before construction starts. But not all the other required personnel need be on hand that early. Physicians, for example, tend to migrate to doctor-shy areas as new hospital facilities become available. You can probably learn from near-by schools of medicine and nursing what your chances are of recruiting an adequate staff.

What Location?

How accessible a hospital is helps to determine how much it will be used. So road conditions, public transportation, and available ambulance service must all be assessed in selecting a site.

In many cases, bus lines and ambulance service have been set up or extended in response to the demand created by a new hospital. But highways don't spring up so easily. Therefore, the hospital should be located, if possible, on hard-surfaced, all-weather roads.

In rural areas, where roads become impassable at times, a road-improvement program ought to be considered as a parallel project to the erection of a hospital.

Another consideration: the near-

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Ask your GE x-ray representative for all the facts on the Model F, the Inductotherm apparatus that *fully* meets today's needs. For illustrated literature, write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Rm. C-4.

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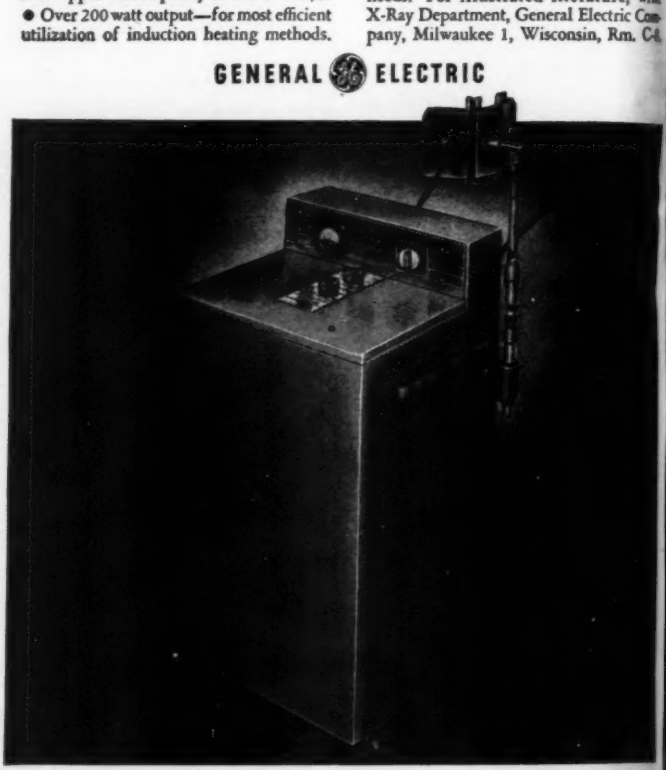

ness of power, water, telephone, and gas lines. And a couple of warnings: Keep away from industrial areas where noise and smoke are more than just nuisances. And don't let any window look out on a graveyard!

Architecture

Hospital design is generally conceded to be about the most complex in the field of architecture. Much of the job must be left to experts. So—except, perhaps, for the facade—sponsors don't have too much to say about the layout of the building, once size and location are set.

Location, of course, often influences the floor plan. In a built-up area, where land is costly, a multistory structure may be mandatory. But elsewhere, there's a lot to be said for a single-story building. In small hospitals, especially, it's considered poor practice to spread a nursing unit (the thirty or forty beds run by one superintendent of nurses) over more than a single floor.

With the help of the above yardsticks, you should be able to answer —and *ask*—many questions intelligently. But remember this: For detailed, precise, and authoritative information about a proposed community hospital, your best bet is to get in touch with a reputable hospital consultant and your state planning agency. END

Hole-in-One

● It was an ideal day for golf. So I was determined to devote the afternoon to it. I'd had a hectic morning, but at last my calendar was clear, and I strode happily into the reception room for a last-minute look-around before taking off.

I had no sooner done so than my spirits went into mourning. The room was jammed with people—of all shapes, sizes, and sexes.

Gloomily, I asked, "Who's first?" Whereupon the oldest occupant followed me into the consultation room.

There, I discovered that the poor fellow had more aches than a two-platoon football team. I had to spend a full hour with him. Meanwhile, there was that line-up of people still waiting for me.

Dejectedly, I escorted the old man back to the waiting room. But then, as I watched, my eyes popping, the entire assemblage arose, and each person, with due respect, fell into line behind the white-haired patriarch as he made his departure.

While driving to the golf club, I reflected happily on the social value of family solidarity. —THEO BOLD, M.D.

A New Era for the G.P.?

[CONTINUED FROM 88]

have taken root in some areas. For example, less than 5 per cent of G.P.'s in Vermont have joined, as compared with 26 per cent in Texas. A third reason, and perhaps the major one, is simply lack of interest. For all these reasons, some academy leaders doubt that it ever will be possible to get more than 25,000 members.

Even among academy members there's some evidence of apathy. Attendance at annual meetings has been falling off; it reached a low of 11,600 at last spring's session—a drop of 20 per cent from the previous year. Academy people blamed bad weather, an uninspiring meeting time and place (Atlantic City in March), the "competition" of top-notch state meetings, and the program—an experimental one, which some charged was of more interest to the press than to physicians. (Commented one general practitioner: "I guess the doctors want the same old stuff from the same old people.")

Fortunately, the academy has not lacked good leadership. Its executive secretary, Mac F. Cahal, is generally conceded to be one of the best in the business. Its top-ranking leaders—men like R. B. Robins, J. S. DeTar, W. B. Hildebrand, Lester D. Bibler, T. E. Rardin, and Stanley Truman—can hold their own in any medical circle.

But there are *too few* men of this stature. And as long as rank-and-file G.P.'s are stand-offish toward organizational work, the process of developing more leaders will be a slow one.

Thus, the G.P. still has plenty of hurdles to clear before he regains his desired position in the world of medicine. But don't underestimate him. He's learned to flex his muscles in the last five years and the results have been heartening, if not spectacular. As one A.A.G.P. man puts it:

"Before the academy was formed, organized medicine was doing things *for* the G.P. Now it's doing things *with* him. We've won back a position on the ball team. If we practice hard, maybe we'll be calling the signals again." END

"Gracious!—Hmm—Great scott! Dear, dear—Oh *no!* Well . . ."

Why Patients Don't Come Back

[CONTINUED FROM 75]

relatively impersonal. But they *don't* like being exposed to the view of others.

The patient felt that little respect was paid to his dignity as an individual.

One woman told me of an occasion when she'd "gone through" a well-known clinic. "I felt like part of an assembly line," she said. "Everything that happened to me was completely standardized. The human element was reduced to zero. Members of the staff referred to me by my clinic number rather than my name; and I seldom saw anyone smile. I bet I went through that place without anyone's remembering I was a human being. I was 'Exhibit A,' that's all."

She added, "It's probably a fine clinic, but next time I'll go where I'm treated like a person, not a *thing*."

"That doctor didn't once remember my name," said one man. "He always had to look on his card to see what it was, and then he usually didn't bother to get it right. Taking my cue from that, I didn't bother to go back to him."

The people I interviewed agreed that there are five ways the doctor can rob the patient of his dignity:

1. Ordering him about, rather than asking for his cooperation;
2. Calling him by the wrong name or no name;
3. Giving him no opportunity to tell his story or interrupting him whenever he starts to talk;
4. Subjecting him to tests or special procedures without explanation;
5. Taking an omnipotent "Doctor knows best" attitude, which brooks no questioning.

Receptionists and doctors' assistants are apparently worse offenders in this respect than doctors themselves. Said one woman: "I've found in the course of several years' visits to physician's offices that there is a certain type of receptionist who specializes in deflating the patient's ego. Her two best tricks are making you wait without even a glimmer of an explanation and constantly referring to her doctor as if he were God Almighty."

Do You Scare Them?

The doctor imposed such strict conditions on further treatment that when the patient failed to live up to them, he was afraid to come back.

Some physicians tell patients something like this: "Now if you slip up, Frank, there's no use coming back to me. I haven't got time to fool with a patient who hasn't the will power to stick by what's best for him. Remember that."

The patient does remember it; and when he slips, as most patients will at least once, he *won't* come back—which is too bad, since the

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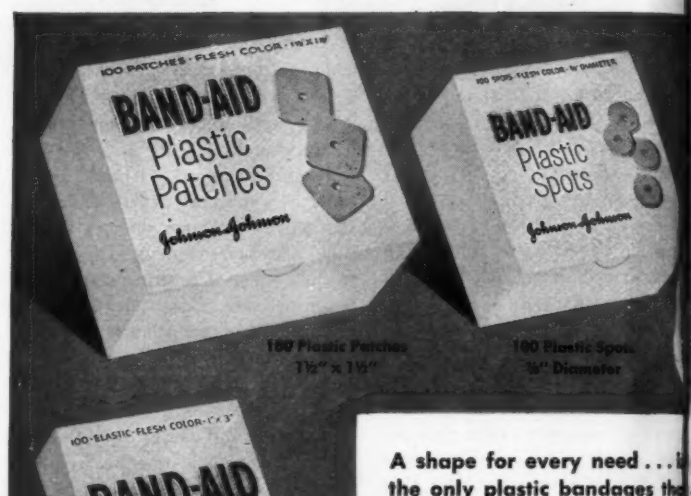

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doctor probably didn't mean what he said. He was merely trying to impress upon the patient the necessity for sticking to the regime prescribed.

Before any M.D. dismisses this point as having no reference to *him*, let him give it a moment's thought. The patients I interviewed mentioned it often enough to indicate that doctors indulge in such stern warnings—if only half-jokingly—more often than one might expect.

The doctor failed to indicate the cost of future treatments, so the patient feared it might be excessive.

Time and again, patients—particularly those in the lower economic groups—said to me, "I was scared of how much it would cost. That's why I didn't go back."

What Others Say

I haven't, of course, pointed out all the reasons why patients don't return. Some go elsewhere because the doctor looked dissipated (or they thought he did, which amounts to about the same thing), or his office looked untidy, or their Cousin Clara said that this particular physician wasn't worth a wooden nickel. But, fortunately, such instances are rare. For the most part, the reasons I've outlined are the important ones—the ones you might well look into.

An interesting point now arises: Why don't patients just say they aren't coming back and let it go at that—rather than accept an appointment they don't intend to keep? There are apparently two answers to this: (1) They don't immediately know they won't be back, since it's only when they've had time to think the matter over that they get steamed up. (2) It's often easiest just to accept another appointment and forget about it.

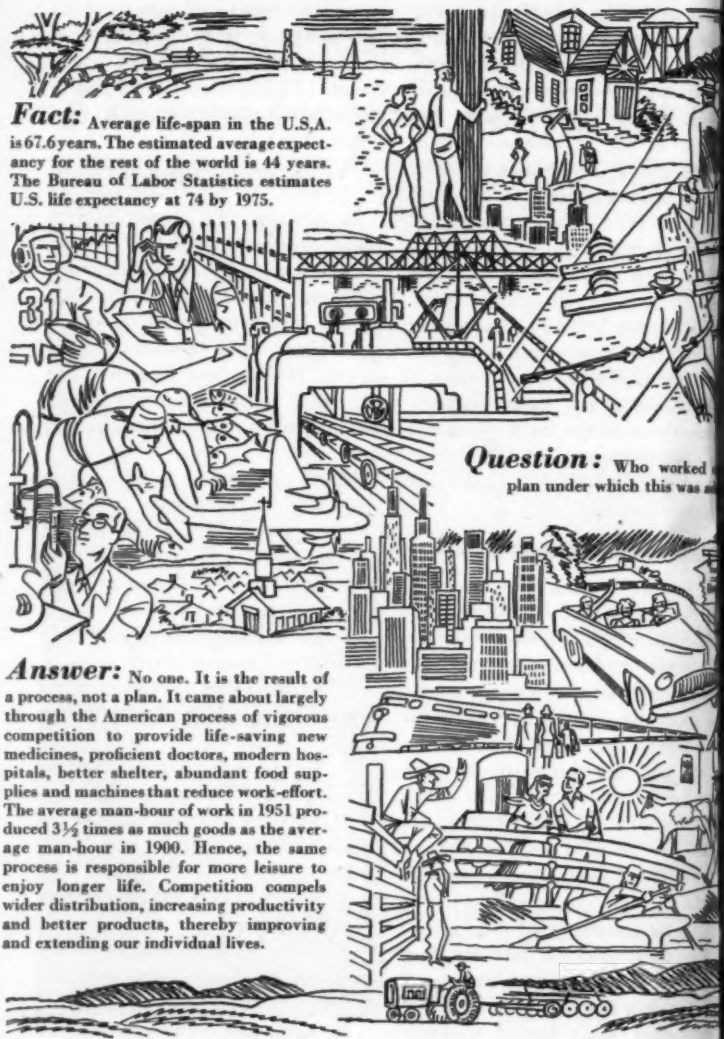
Points to Watch

In any case, it's a good idea to check your own habits that may be alienating patients. If you find yourself answering "No" to less than five of the following questions, you're probably doing all right. If you have to say "No" to more than five, you can stand a little brushing up; to more than ten, you'd better watch out.

When patients are in your office, do you:

1. Maintain a reasonable degree of calmness?
2. Avoid unpleasantness between your assistants and yourself?
3. Occasionally check yourself for irritating mannerisms?
4. Make a consistent effort to keep your mind on the matter at hand?
5. Go through your examination in a logical, well-planned way?
6. Keep all expressions of bewilderment and self-doubt to yourself?
7. Give patients an opportunity to ask questions?
8. Make an honest effort to answer the questions clearly and tactfully?
9. Keep any social conversation to the minimum required to put the patient at ease?

[MORE→



Fact: Average life-span in the U.S.A. is 67.6 years. The estimated average expectancy for the rest of the world is 44 years. The Bureau of Labor Statistics estimates U.S. life expectancy at 74 by 1975.

Question: Who worked
plan under which this was

Answer: No one. It is the result of a process, not a plan. It came about largely through the American process of vigorous competition to provide life-saving new medicines, proficient doctors, modern hospitals, better shelter, abundant food supplies and machines that reduce work-effort. The average man-hour of work in 1951 produced 3½ times as much goods as the average man-hour in 1900. Hence, the same process is responsible for more leisure to enjoy longer life. Competition compels wider distribution, increasing productivity and better products, thereby improving and extending our individual lives.

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THE COMPETITIVE SYSTEM DELIVERS THE MOST TO THE GREATEST NUMBER OF PE

10. Leave discussion of minor office repair jobs for a time when no patients are present?

11. Avoid lecturing the patient or attempting to arouse guilt feelings in him?

12. Avoid embarrassing him by working toward intimate questions gradually rather than asking them abruptly?

13. Avoid reacting too emotionally to anything the patient may tell you?

14. Restrain yourself from joking about his weight, physique, etc.?

15. Make a definite effort to show him his due as an individual by remembering his name and treating him with common courtesy?

16. Explain the purpose of most of the things you ask him to do?

17. Avoid making the patient feel that if he fails to follow your advice, he'd better not come back?

18. Clearly indicate the probable cost of future visits?

19. Attempt to demonstrate to the patient that he isn't wasting his time in your office?

20. Encourage your assistants to treat patients with the same courtesy they accord you—or maybe even more?

By and large, physicians are probably just as pleasant to deal with as members of any other profession. (I've cited some pretty nasty specimens in this article; but they were obviously extremes, chosen for their value as illustrations.) Yet irritating little habits and mannerisms can do much harm. It won't hurt the doctor to check on himself at regular intervals. END

Sickroom, Shaggy Style

• In the course of making a house call recently, I was greeted in the yard by a big, nondescript Collie. He followed me to the door and, when the patient's wife opened it, pushed in ahead of me.

No sooner had we entered the sickroom than the dog jumped up on the bed and began licking the patient's face. This show of affection was all right, except that I had to examine the man and the dog kept getting in the way.

It wasn't long before I began to get a bit irritated. I wanted to ask the man to get his confounded pet off the bed. But I hesitated to offend such an indulgent dog-lover.

After I'd completed the visit and was halfway down the front walk, I heard a sharp rapping on the window. It was the patient's wife. "Doctor," she shouted, "you forgot your dog!"

—JOHN C. SOUDERS JR., M.D.

The Newsvane

Spot Check Indicates More Towns Now Taxing M.D.'s

The privilege of paying an additional tax—on top of Federal, state, and county levies—is being extended to more and more physicians by their home towns. A MEDICAL ECONOMICS spot check of thirty cities and towns in thirteen states reveals that 46 per cent are now collecting "municipal license" fees, "business privilege" taxes, or "business and occupation" taxes from professional men as well as from barbers, butchers, and junk collectors.

In some spots, the tax supplements a registration fee of $1 to $5. "All this," an Alabama doctor remarks, "and the charity load in the municipal hospital too."

Some towns levy an annual flat fee. For example, Ogden, Utah, calls for $10 a year; Tampa, Fla., $35; Eufaula, Ala., $50. But among the cities in which the spot check discloses a business tax, at least half base it on gross income. Seattle's is 1/10 of 1 per cent of gross income bimonthly. Birmingham's varies on a sliding scale from $25 to $100. In Los Angeles it's 1 per cent of gross income annually, with a $12 minimum.

"Gross income taxes are legal in Virginia towns if you call 'em license fees," a Virginia doctor comments wryly. In Staunton it's $50 on the first $5,000, 30 cents per $100 on the rest. In Richmond it's a sky's-the-limit 1 per cent of gross income, plus $20.

The spot check shows more of these local taxes in southeastern and western states than elsewhere, more in small towns than in large ones. For example, a move to tax professional men has been nipped in San Jose, Calif., but the neighboring town of Gilray, only a fraction as large, collects $25 annually from every physician.

Want to Be President Of A.M.A.? Get Wings

What price the presidency of the A.M.A.? Judging from the activities of Dr. John Cline, lately retired from that office, it demands at least two things in heroic quantities:

¶ Time: roughly, eight months a year. Speaking engagements, inspection tours, and other official duties kept Dr. Cline away from his San Francisco practice two-thirds of the time.

¶ Travel: Missions during his presidency account for Cline's having set a record: He did more flying

Isatin – the new laxative principle

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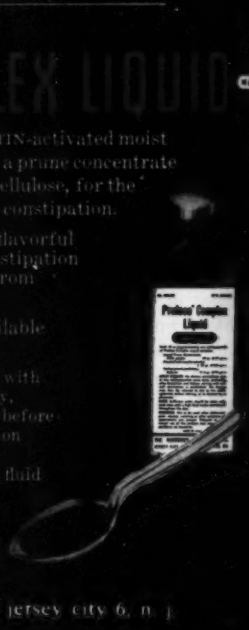

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in a single year than any other passenger in United Air Lines' history —125,000 air miles. A sample from his travel log shows that in one five-week period alone A.M.A. activities took him on two transcontinental round trips, plus an additional jaunt from San Francisco to Chicago and back.

Finds It Now Costs More To Hang Out Shingle

The essentials for practicing medicine may still fit into one head and one bag, but the trend appears to favor more extensive facilities. The fledgling doctor opening his first office today has to buy furniture, equipment, instruments, and supplies worth from $2,000 to $10,000. At least that's the report of Henry J. Scherck, vice president of the A. S. Aloe Co., and you may be interested in comparing his figures with the cost of your own shingle-hanging.

Scherck's report, published in The Journal of the Student American Medical Association, shows that outfitting a three-room office (reception, consultation, and examining-treatment rooms) is likely nowadays to cost some $1,400. To provide amply for a secretary, the physician can invest an additional $375. If he hankers for diathermy, electrocardiograph, and B.M.R. equipment, he can spend about $1,600 more. A completely equipped X-ray room will call for $1,400 to $4,400. And if he's starting a general practice he'll probably want a basic $800 worth of instruments and supplies.

A room-by-room breakdown of costs of furniture and equipment, as Scherck sees them:

Room	Medium-priced	De luxe
Reception	$408	$858
Secretary's office	375	471
Consultation	418	817
Examining-treatment	618	887

Estimates of costs of instruments and supplies in selected fields:

General practice	$806
Urology	637
General surgery	548
Internal medicine	421
Pediatrics	341

Reports Vast Progress in Emergency-Call Plans

Most of the larger medical societies (nearly 90 per cent) have emergency-call plans, and about three-fourths of the societies with 200 to 300 members have them. At least 364 such plans are now functioning in the U.S., according to a survey released by the A.M.A. Council on Medical Service.

Since only sixty emergency-call plans existed in 1948, the latest total figure represents an increase of 600 per cent in three years, the council finds.

Appealing for support of these plans, it points out that "inability to put physicians in immediate contact" with emergency cases is a weak spot in any medical care program. "Some physician has to make

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the emergency night call," the council emphasizes; "every physician should do his part so that the burden does not fall on the few."

Urges M.D.'s to Get Off High Horses

Doctors have been admonished ad nauseam to treat the patient as a person. But this isn't going far enough, says Rollen Waterson, executive secretary of the Alameda-Contra Costa (Calif.) Medical Society. He urges doctors to respect the patient as an *equal* person. Failure to do so, he warns, may result in resentment instead of appreciation.

Waterson blames a possible defect in our medical education—or in our culture—for the illusion that doctors are "different" from other people. Insisting that they aren't, he advises them to discard their artificial bedside manner of superiority: "Patients can see through it."

If physicians will only treat their patients with man-to-man sincerity, he says, "they'll get appreciation, even when they fail."

Rx Tie-Up Between M.D.'s And Druggists Exposed

"Physicians Gouging Patients in Hookup With Pharmacists." To blasé New Yorkers passing their newsstands not long ago, this eye-catching headline in The New York World-Telegram and The Sun promised some exciting reading.

Nor were they disappointed. For,

Rollen Waterson
Are doctors really different?

according to the article, "an undisclosed number of doctors, operating a new-fangled and unethical prescription dodge," were mulcting "thousands of patients." The doctors and their druggist-partners, it added, were "averaging $2,000 to $5,000 each" in annual "dividends."

The set-up described by the paper was this: "Doctor A, B, and C met privately and organized a 'pharmaceutical team' . . . [then] they invited other doctors to buy $100 to $300 shares in the 'team.' "

Once organized into "dummy corporations," the physicians allegedly bought drug items, of often dubious quality, from unapproved manufacturers. Labels were switched, new names attached, and the drugs moved to the shelves of neighborhood druggists, who bought stock in turn.

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"Then [doctors and druggists] split the loot obtained from giving patients more and costlier prescriptions than were necessary."

For several weeks the story blazed on the newspaper's pages, with new disclosures served up daily. "State Probes Prescription Ring," said one headline. "Net Closes on Higher-Ups in M.D.-Prescription Dodge," screamed another. The "dodge," first revealed as existing in Brooklyn, was soon discovered to flourish in other parts of New York City, and even in neighboring states.

Later stories gave fresh details of methods that the venal doctors were using to boost sales of their special drugs. Some of the physicians, according to the newspaper, telephoned prescriptions directly to friendly druggists. Others allegedly wrote prescriptions in a special code, thus compelling patients to patronize the favored druggist who alone could decipher it.

Readers tempted to discount the exposé as mere press sensationalism were in for a surprise. For not long after the story broke, New York State's Attorney General Nathaniel L. Goldstein announced that "It certainly appears, even at this early stage, that there exists a highly questionable relationship between certain members of the medical profession and certain drug companies and druggists." More than 1,000 M.D.'s and pharmacists were apparently involved, he said; and a full-scale inquiry was under way.

Further confirmation came from the Kings County (Brooklyn) Medical Society. A society statement, signed by President Charles H. Loughran, said: "We have been cognizant of this situation [for] some time," and explained that lack of concrete information had held up disciplinary action. Dr. Loughran hoped that the publicity "would bring forth reputable physicians" to make charges against unethical members.

So far, the Attorney General has turned down offers of New York's five county medical societies to help investigate his list of suspects. His own staff, he says, will sift the evidence for criminal violations. According to a spokesman for the Attorney General's office, "this takes time and much care"; so progress may be slow.

"Under [New York's] Martin Act," explains the spokesman, "we must prove that there has been fraudulent sale of corporate stock . . . Under the Education Law we must prove disregard for professional ethics leading to revocation of licenses in New York for both doctor and druggist."

Are Part-Time Salaried Doctors 'Employes'?

Several M.D.'s held contracts between 1943 and 1947 to give in-plant care during specified hours to employes of the Willard Storage Battery Company, of Cleveland, Ohio. They received annual retain-

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1. Duncan, G. G., ed.: Diseases of Metabolism. Ed. 2. (Philadelphia: W. B. Saunders and Co.), 1947, p. 352.

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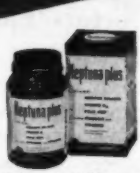

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VITAMIN A	5,000 U.S.P. Units
VITAMIN D	500 U.S.P. Units
THIAMINE HYDROCHLORIDE	2 mg.
RIBOFLAVIN	2 mg.
PYRIDOXINE HYDROCHLORIDE	0.1 mg.
NIACINAMIDE	10 mg.
CALCIUM PANTOTHENATE	0.33 mg.

With other B-Complex Factors from Liver.

J. B. ROERIG AND COMPANY, 536 LAKE SHORE DRIVE, CHICAGO 11, ILL.

ers of up to $2,500 apiece. But they spent most of their time on—and received most of their income from—private practice.

Were these doctors employes of the company? The Bureau of Internal Revenue said that, for tax purposes, they were. So the company paid a total of $3,403 in Social Security and unemployment taxes on their behalf.

Willard remained unconvinced, however, that the physicians really were taxable employes; and in 1949 it brought suit against the Bureau of Internal Revenue for return of the $3,403.

When the case came to trial, B.I.R. attorneys argued that the company had treated its doctors like employes, that it had given them turkeys and bonuses at Christmas time, that it had even paid them on a monthly basis. This in itself, the lawyers said, constituted a legal employe-employer relationship. In addition, the doctors (two of whom held Social Security cards) turned in reports on Willard company forms.

While Federal Judge Paul Jones was writing his decision, organizations representing many thousands of doctors, lawyers, architects, and other professional consultants waited anxiously. For if the Bureau of Internal Revenue won the case, many professional men now exempt from Social Security would become subject to payroll deductions.

But now the court's decision has cleared the air, at least temporarily. Says Judge Jones: "These physicians were not, in my opinion, employes."

His reasons, in part:

1. Contracts gave the doctors carte blanche to carry out their duties "in accordance with the best established practice," without detailed supervision by the company. "There was not . . . that degree of control over . . . the physicians which would indicate an employer-employe relationship."

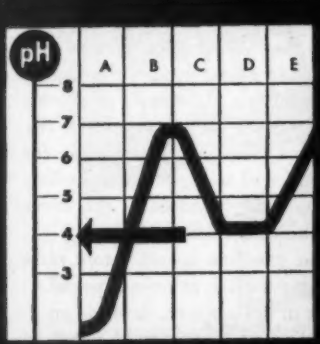
2. The doctors were private practitioners first, industrial M.D.'s second. "They were free to leave company premises even during the hours they were scheduled to work, if an emergency case in their private practice required their presence."

The bureau has announced that it will appeal the decision.

One More British Worry: How Much for a Sidecar?

Add to the headaches of Britain's National Health Service administrators: miles of red tape about mileage allowances. A recent directive from the Ministry of Health has granted increases in such allowances for travel in a physician's own vehicle. To cover all contingencies, the directive offers a rate schedule for six modes of transportation, including such conveyances as the tricar and the motor-bike.

The schedule specifies two rates for automobiles, to recognize differences in horsepower. And—as an illustration of the maze of detail in



The normal adult vaginal mucosa is relatively thick, ric glycogen and its secretions have an acidity within the n of pH 3.8 to 4.4. Glycogen is metabolized to lact acid by the Döderl bacilli, thus maintaining the no acid state.

The normal pH of vaginal secretions varies during the lif of the female as sho by the red curve. Th normal adult pH during maturity is approximately 4.

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Through the Menstrual Years of Life . . .

THE frequency with which the menstrual life of so many women is marred by functional aberrations that pass the borderline of physiologic limits, emphasizes the importance of an effective uterine tonic and regulator in the practicing physician's armamentarium.

In ERGOAPIOL (Smith) with SAVIN the action of all the alkaloids of ergot (prepared by hydro-alcoholic extraction) is synergistically enhanced by the presence of apiol and oil of savin. Its sustained tonic action on the uterus provides welcome relief by helping to induce local hyperemia, stimulating smooth, rhythmic uterine contractions and serving as a potent hemostatic agent to control excessive bleeding.

May we send you a copy of the booklet "Menstrual Disorders", available with our compliments to physicians on request.

MARTIN H. SMITH COMPANY
150 LAFAYETTE STREET, NEW YORK 13, N. Y.

which Government planning can lose itself—it lists two rates for motorcycles also (to allow an extra halfpenny per mile for those with sidecars).

Lawyer Scores Doctors Who Testify Falsely

Doctors are the most important witnesses in damage suits, yet they often give "basically false testimony." The result, according to Baltimore Lawyer Robert E. Coughlan Jr., is frequent miscarriage of justice in our courts.

Misleading medical testimony at its most flagrant can generally be heard, says Coughlan, when the plaintiff in a damage suit has one of these "popular" disabilities, a back or head injury. In many such cases, he maintains, doctors base their findings on the plaintiff's word alone.

When a head injury is in question, "less conscientious doctors will testify that the patient is suffering from a post-concussional syndrome." Then, says Coughlan, when asked if the complaint of pain is justified, they give their "standard" answer:

"I believe so. And it's not unusual for these symptoms to persist for as long as a year, and many times they become permanent."

Curiously enough, though, adds Coughlan, "experience has shown, over a period of years," that the average plaintiff's back or head stops bothering him once the case is settled.

Because juries tend to favor the underdog, he continues, this misleading medical testimony "creates a hazard to which defendants and insurance companies should not be exposed."

But it's not only the doctor for the plaintiff who trims his testimony to the wind. To offset the "exaggerations" of the plaintiff's physician, Coughlan points out, the physician for the defendant is quite likely to "*underestimate* the percentage of disability."

Of course, honest differences of medical opinion are possible. But there's something wrong, asserts Coughlan, when one M.D. testifies that a man has suffered a 50 per cent loss of the use of his back, whereas the opposing doctor says there's only a 5 per cent disability, or none at all.

How can such abuses be prevented? Coughlan makes three suggestions:

1. Doctors should agree on a method of evaluating disability.

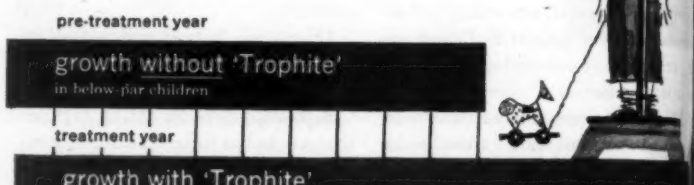
2. A board of competent physicians should be set up to review medical testimony in which there is a divergence of opinion.

3. Organized medicine should "do something" about its unscrupulous members.

But Coughlan is aware of the main obstacle to his proposed reforms: "The difficulty lies with the doctors. The men of high standing . . . are horrified when examples of distorted testimony are brought to their attention, but they become squeamish about taking any steps

how 'Trophite' increased growth

in a one-year clinical trial



Average Development Rate—Levels/Year (Wetzel Units)
These levels represent growth in terms of both height and weight.

FORMULA: Each *delicious* teaspoonful supplies Vitamin B_{12}, 25 mcg.; and Vitamin B_1, 10 mg.

DOSAGE: *One teaspoonful daily.* If desired, 'Trophite' may be mixed with water, milk, fruit juice or vegetable juice.

PRESCRIPTION SIZE: 'Trophite' is supplied in 4 fl. oz. bottles —enough for 24 days' treatment at the recommended dosage.

TROPHITE*

to increase appetite and growth in below-par children

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Smith, Kline & French Laboratories, Philadelphia

to correct it. They do not wish to become involved . . . It is a breach of professional etiquette to testify against another doctor or in any way take him to task.

"Thus," he concludes, "the unscrupulous doctor continues to give false testimony, juries are misled, defendants pay much more than they should, and the evil continues."

Does This Dope Addict Now Sing Soprano?

When a down-at-the-heels character wormed his way into Citizens Emergency Hospital in Los Angeles one night recently, with a phony plea for treatment, he was led into an examining room by the physician on duty, Dr. Grover C. Pritchet. There he drew a gun on Dr. Pritchet, backed him into a treatment chair, and taped him to it. Then he ransacked the place for "all the dope in the joint" and escaped with his loot in a pillowcase.

After freeing himself, Dr. Pritchet notified police: Along with about $400 worth of narcotics, the tough guy had carted away enough female hormones to tenderize himself considerably.

Committee Blazes Trail For Election Campaigns

Medical societies seeking a blueprint for election-season activities can study one used by Florida physicians, who made an early plunge into the political swim during the

Grover C. Pritchet
He got the tape treatment

state primaries last spring. Their contribution: a non-partisan educational campaign, which extracted vital statements from each candidate and passed them on to the public.

This pattern of campaign activity was worked out by the Florida Medical Committee for Better Government, an independent organization open to any state-licensed physician. Here's what the committee did:

1. It sent out a twenty-item questionnaire on important issues to each candidate for high political office. (Questions covered taxes, state and national budgets, graft, farm subsidies, and veterans' bonuses, as well as Federal aid to medical schools, compulsory health insurance, V.A. free medical care to veterans for non-service-connected dis-

abilities, and Ewing's proposal for free hospitalization for the aged.)

2. It informed every doctor in the state, by letter, of the candidates' replies.

3. It ferreted out county candidates' views for physicians in their respective counties.

4. It released news stories to publicize the candidates' statements—and, incidentally, the doctors' interest in civic affairs.

5. It sent every physician a booklet urging him to register and vote.

Reviewing the campaign, Dr. Robert E. Zellner, secretary of the committee, observes that such activities serve two purposes:

¶ They alert candidates to the importance of the medical vote; and

¶ They inspire doctors to take a livelier role in public affairs.

Blue Shield Plan Gets an Exploratory Laparotomy

How do Blue Shield plans fall short of physicians' expectations, and what can be done about the shortcomings?

No doctor-sponsored prepay plan has had more experience than the thirteen-year-old California Physicians' Service; yet it still leaves a number of doctors dissatisfied or openly antagonistic. So a special study committee of the state medical society, under the chairmanship of Dr. Wilbur Bailey, is giving C.P.S. a searching reappraisal that may throw light on problems of other Blue Shield plans.

An interim report from the committee indicates that many criticisms of C.P.S. are unwarranted. Some doctors, for instance, object to the paper work involved. Others resent restrictions designed to prevent abuse of the plan. Still others are bitter about third-party interference between doctor and patient. To such complaints the committee has a short answer: These are necessary conditions "with which we must learn to live."

For another major difficulty—"confusion as to the objectives of C.P.S."—the committee puts the blame squarely on the doctors: "We . . . must accept the responsibility for having failed to plot the course [for] C.P.S. . . . The medical profession must first decide what role it wants C.P.S. to play." The role of paymaster, for example, needs clarifying, in line with complaints of "inadequate financial return to the physician."

But there are, the committee points out, certain defects in the plan that can be easily remedied. For example:

1. *Multiplicity of contracts.* The committee finds that C.P.S. offers too many unnecessary variations on its basic contract. This irritates doctors and confuses patients.

Remedy: Simplify the structure as rapidly as possible, partly by resisting special-interest "demands for minor modifications of contracts."

2. *Unsatisfactory method of payment.* Since C.P.S. follows the service-type plan and pays off the doc-

in Others' Words

An Air Force Medical Officer:

"I am much impressed by your campaign for medical school funds. Enclosed please find a check for $100.00. I am only a first lieutenant in the Air Force but the realization that such a contribution from every physician in the country could save our medical freedom impels me to give this large portion of my salary—with great pleasure.

"I plan to send you at least this much every year."

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If you have missed doing your part—why not send your contribution today. All gifts can be earmarked for any one of the approved medical schools—and the money is income-tax deductible. Send your check now.

American Medical Education Foundation

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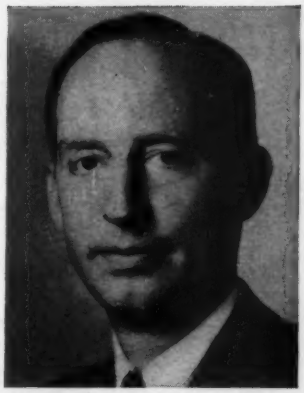
tor directly, the patient too often doesn't appreciate what his insurance has done for him. Some medical men argued that C.P.S. should substitute indemnities to patients.

Remedy: The committee distrusts indemnities to patients, particularly to those in low-income groups. In serious illnesses, service-type payment is more satisfactory, even for moderate-income people, it finds. So it advises C.P.S. to devise some simple method of informing each patient pointedly of the value of the medical services his insurance is paying for.

3. *"Defective liaison" between C.P.S. and organized medicine.* C.P.S. "has been forced to conduct its own disciplinary actions, but is afraid to do so . . . [it] has not been accorded its rightful position within the family of medicine; it has been a stepchild . . . that approaches state and county medical societies with hat in trembling hand."

Remedy: Set up a special committee in each county society for liaison with C.P.S., "for mediation, and, if necessary, for action in instances of abuse."

4. *Impersonal coldness of C.P.S.* Doctors have objected to the curtness with which C.P.S. rejects about one out of every four claims, in spite of the time and trouble spent in filing them out. Acting with the abrupt efficiency of its check-writing machines, C.P.S. "communicates its rejection with a printed form which lacks human courtesy and consideration," the committee finds.



Wilbur Bailey
What next for Blue Shield?

Remedy: A shift toward friendlier business contacts with physicians.

5. *High-cost coverage of small expenses.* The plan's present coverage of ordinary house- and office-call fees has been criticized because, at high cost to the subscriber, it pays for small medical expenses that he could easily meet. Moreover, this coverage "invites abuse, it is costly to administer, and it multiplies the opportunities for petty friction between patients, doctors, and C.P.S.," according to the committee.

Remedy: "Some method of gradual limitation . . . must be devised."

6. *Poor Blue Cross-Blue Shield relations.* Medical and hospital service plans should complement each other and should be sold and administered together, the committee believes. But in California the schism between C.P.S. and Blue

A concentrated B Complex in a cola-flavored syrup

THIS IS THE FORMULA...

Each 30 cc. (1 fl. oz.) contains:

Thiamine Hydrochloride..... 36 mg.
Riboflavin..... 3 mg.
Niacinamide.....180 mg.
Panthenol..... 6 mg.
(Equivalent to approx. 7 mg. calcium pantothenate)
Pyridoxine Hydrochloride.....6 mg.
Vitamin B_{12}.....12 mcg.

—in a delightful cola-flavored syrup.
—Bottles of 8 fl. oz. and one pint.
Samples on request

Cross has resulted in unprofitable competition.

Remedy: Let the state medical society negotiate with Blue Cross for coordination with C.P.S.

The committee admits having found no solution for several other problems, notably: (1) where to fix income ceilings for C.P.S. contracts, and (2) how to set fair fee schedules that are consistent with the income levels of subscribers.

Of one thing, though, the committee is convinced: Despite its defects, California's Blue Shield plan must be continued. The reason: Prepayment coverage for serious illness is "a modern social necessity." Doctors must guide it because "he who controls the payment of medical care costs controls medicine."

Which brings up the silver lini in this study of "mutual failing The committee finds it in "the f that it is we, and not a state bure who today are deciding the dir tion in which health insurance w go in California."

Hospital's Right to Bar Surgeon Tested in Court

The much-argued question of wh shall do major surgery is now bei thrashed out in a New Jersey co as a result of a suit against the st of the municipally run Irving General Hospital.

Charging that the hospital h wrongfully barred him from maj surgery, 42-year-old Dr. Willia Jacobs maintains that it is legall

bound to honor his state license, which does not differentiate between major and minor surgery.

Then what's to stop a man from attempting operations beyond his skill? His conscience, says Dr. Jacobs, pointing out that he refrains voluntarily from any surgical procedure that he considers too complicated.

The defense maintains that a state license confers no basic right to practice in municipal institutions. On the contrary: A municipal hospital has an obligation to the public, defense counsel has asserted, to screen surgeons so that only "qualified experts" practice major surgery, conscience or no conscience.

Report Shows Hospitals Crowded But Efficient

More patients than ever before (one every 1.7 seconds) were admitted to U.S. hospitals last year, but they stayed only two-thirds as long as patients used to seven years ago. So finds the A.M.A. Council on Medical Education and Hospitals in its annual report on hospital service.

In all there were 18,237,118 hospital admissions last year—an increase of nearly 1¾ million over 1950, and well over twice the total back in 1935.

The average patient's stay at all general hospitals is 10.1 days, a drop of 5.8 days since 1945. But it's the non-governmental hospitals that have by far the lowest average: 7.7 days. In Federal, state, and local government hospitals, the hospitalization period averages more than twice as much (17 days).

Other highlights of the report, which was written by Dr. F. E. Arestad and Mary A. McGovern:

¶ Psychiatric hospitals, "where longer periods of hospitalization are necessarily required," shoulder a particularly heavy patient load. Their average daily census: nearly 700,000, "which is greater than the combined patient load in all other registered hospitals."

¶ About 216,000 graduate nurses were employed by A.M.A.-registered hospitals during 1951—an increase of more than 10,000 over the preceding year.

¶ More hospitals are granting additional staff privileges to qualified G.P.'s.

¶ Approximately 34 per cent of all general hospitals now have general practice sections.

For Bag Pilferers: a Dose Of the Wrong Medicine?

A broken car window, a snatched bag, an escaping thief—and a narcotics addict has probably added to his store of morphine. As a result, the doctor from whom the bag was stolen suffers considerable financial loss as well as annoyance. How can physicians guard against these splashes from the narcotics crime wave?

A doctor by the name of Edwin Corbin proposes a drastic step: "Put apomorphine or some other unpleas-

"for the want of a nail..."

The question of choice of soap may seem unimportant to your dermatologic case, but the physician of today appreciates the fact that the use of an irritating soap can aggravate a skin condition and materially retard therapy.

For more than a quarter of a century, physicians have used this dual therapy in acute and chronic psoriasis, eczema, alopecia, ringworm, athlete's foot, and other skin conditions not caused by or associated with systemic or metabolic disturbances.

MAZON is greaseless . . . requires no bandaging; apply just enough to be rubbed in, leaving none on the skin.

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antacids neutralize acidity but stop protein digestion

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Al-Caroid relieves gastric acidity promptly without retarding gastric digestion.

Al-Caroid speeds both the digestion and assimilation of needed proteins.

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ant drug in the tube marked morphine. Actual morphine could be concealed under a different label."

This, he realizes, might not prevent the crime; but it would make the punishment fit it. At least, says Corbin, the culprit would be miserable. And the apomorphine might even land him in a hospital bed, both identified and trapped.

The catch: "What are the legal aspects?"

Tells 'Merchandiser' He Discredits Profession

"My fee is higher than a G.P.'s because I'm a specialist. My extra training and experience set me apart from the rank and file. If I should lower my fee, I'd forfeit my special standing."

An unidentified physician who expressed this point of view has been rebuked by Dr. Ralph A. Johnson, an editor of the Detroit Medical News. Specialists who charge more than G.P.'s for the same service, says Johnson, are guilty of fallacious and dangerous reasoning—"if it can be called reasoning."

Everyone, he adds, has a right to set his own fee. But "to charge all that the traffic will bear reflects discredit on the rest of the profession."

Men like the specialist under discussion—"fortunately only a minority"—aren't really doctors at all, but "merchandisers," says Dr. Johnson. "They are primarily concerned with what they *get*, forgetting that the doctor's reward comes for what he *does* . . . In the last analysis, the reward for service rendered by any physician or surgeon pivots upon one elementary fact: *Have you earned it?*"

Ralph A. Johnson
Raps fee-haughty specialists

Malpractice Precautions In a Nutshell

Reams have been written about preventing malpractice. But now an expert has boiled the subject down to forty-eight well-chosen words. In a recent speech to county medical society officers of New Mexico, Raymond Wagner, U.S. Fidelity and Guaranty Company insurance investigator, advises:

¶ "Don't talk so much;

¶ "Don't charge so much;

¶ "Don't criticize other doctors;

¶ "Don't criticize other members of the healing arts; [MORE→

¶ "Don't keep patients waiting so long;

¶ "Don't destroy records;

¶ "Be sure to take X-rays whenever it seems advisable;

¶ "Don't fail to keep an inventory of sponges and instruments."

Health Agency Research Budgets Analyzed

Are voluntary health agencies backing research in the most urgent battles against disease? At least three organizations set aside more than a million each for research projects annually, three others more than $100,000—and three, none at all. Is this money allocated in proportion to current needs?

One way to judge the need for research is to determine the number of deaths or disabilities due to each disease. On this basis, the latest figures (as compiled by the Albert and Mary Lasker Foundation) show up some significant discrepancies.

For example, the National Foundation for Infantile Paralysis allotted $2,300,658 to research in 1950. In that year, an estimated 2,720 people died of polio. Research expenditures, then, averaged $845.83 per death.

In the same year, an estimated 25,000 died of diabetes; the American Diabetes Association's research fund was $1,953—or $.08 per death.

In terms of the vast numbers of patients disabled by certain diseases, most research expenditures seem hardly adequate. The 1950 research budget of the Arthritis and Rheumatism Foundation amounted to $225,630. Assuming about 7,500,000 sufferers from arthritic and rheumatic ailments, that sum works out to $.03 per disability.

Among the health organizations that are unable to support any research at all are those dealing with deafness, syphilis and gonorrhea, and epilepsy.

A partial line-up of other voluntary agencies and their research budgets per individual death and disability:

Name of Agency	Spent per Death	Spent per Disability
American Cancer Society	$18.03	$3.49
American Diabetes Association	.08	.002
American Heart Association	1.25	.09
National Assn. for Mental Health	—	.005
National Multiple Sclerosis Society	—	.38
National Tuberculosis Association	5.36	.42

Second-Choicers Say They Wish They Were Doctors

Medicine is an enviable career, in the opinion of discontented college graduates who aren't doctors. And physicians themselves appear to agree.

These facts emerge from a chapter in a recent Time magazine study of college graduates, published in book form under the title, "They

Went to College." A cross-section of graduates were asked two related questions:

¶ Do you wish you had studied for another profession?

¶ If so, which?

A tabulation of answers indicates that physicians are more satisfied with their profession than any other group. While revealing that 25 per cent of all graduates regret their choice of career, the survey sets the figure for disgruntled medical men at only 9 per cent.

The study classifies graduates in fifteen categories, according to major fields of interest at college. In four of the fifteen, graduates who registered a desire for change say they wish they'd chosen medicine; that's twice as many as agree on any other profession.

Among the malcontents who now apparently wish they were doctors:

¶ 14 per cent of those who studied law;

¶ 27 per cent of those who specialized in agriculture and forestry;

¶ 33 per cent of those who majored in the humanities;

¶ 33 per cent of the graduates in pharmacy.

Loss of Art of Medicine Called Drag on Science

Are you an automatic dispensing machine? Medicine has too many of these, in the opinion of Dr. Melvin Casberg, chairman of the Armed Forces Medical Policy Council. As a result, he says, physicians keep hearing the plaintive appeal of the patient buffeted from one specialist to another: "I want a doctor who is interested in *me*!"

Melvin Casberg
Is science so golden?

Too many physicians have lost the personal touch, Casberg believes, in this "so-called golden age of scientific medicine." Busy keeping abreast of new developments in science, they neglect the *art* of medicine—which he defines as the application of scientific knowledge through "that delicate mechanism brought into play by the physician-patient relationship."

While the doctors have been stressing science, he warns, "certain fringe orders of the healing fraternity have appreciated the full significance of the art of medicine and have exploited [it] with evident success."

Since this art cannot be passed on

from generation to generation like a learnable formula, says Casberg, each new doctor must develop it for himself. Human nature responds best, he declares, "to a healing potion dispensed . . . with the personal interest of the dispenser."

Without advocating an all-night vigil over each pneumonia case, he nevertheless urges the physician to do more than scribble a penicillin prescription and run, leaving the directions to be relayed by the corner druggist. "The art of medicine," he says, "*must* be revived."

Rigid Hospital Routine Called Bad Medicine

When patients complain about hospitals, they generally have his sympathy, says Dr. D. G. Miller Jr., of Morgantown, Ky. Here are some examples, according to Miller, of the irritatingly inflexible routine current in most hospitals:

¶ *Uniform mealtimes,* regardless of individual habits. Patients accustomed to dinner at 7 are dismayed at a 5:30 supper without hope of bedtime snacks, he has noticed; and early-waking farmers suffer when breakfast trays don't arrive till 9 A.M.

¶ *That* 6 A.M. *reveille.* Miller calls this a special nuisance to patients who, after a restless night, might get some morning sleep if not disturbed. Why are they roused to an early start on a dreary, empty day? "Merely because custom demands that the night shift see that faces are washed and teeth are brushed."

¶ *The rigid T.P.R. charting schedule.* Why not spare the afebrile patient that 2 A.M. temperature reading? asks Miller. He warns that the unvarying interval often fails to catch fleeting temperature variations anyway.

¶ *Inflexible curfew*: lights out and radio off at 8:30, sedative or not. Miller finds this enforced quiet a hardship for patients accustomed to late hours. There's justification for muffling radios, he admits, but he maintains that reading in a private room can disturb no one.

¶ *Stingy visiting hours.* While it's true, says Miller, that housekeeping and nursing routines must be maintained without visitors underfoot, why bar them from the restless diagnostic case who gets no care except an occasional change of bed linen?

¶ *Isolation of new babies.* It's reasonable to protect them from infection, of course. But Dr. Miller sees no necessity for secluding them from healthy relatives who'll soon be caring for them at home.

¶ *Routine procedures.* He doesn't blame patients for squawking at unexplained enemas, catheterization, and the taking of blood specimens. "It is the duty of . . . the physician . . . to explain the need for these," he believes; otherwise, the victim may think them "baseless, useless, painful, and in many cases expensive and unjustified."

And much laboratory work *is* unnecessary, he argues. Before send-

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*methyl*bromide is 30 to 50 times less likely to p
side-effects than atropine—a wide safety m
Furthermore, the Alukalin in Lusyn pr
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but homatropine methylbromide
for safe and effective
spasmolysis

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and Alukalin does not
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ound. Restlessness and
xiety are calmed by the mild
lative action of phenobarbital,
ich also reinforces the
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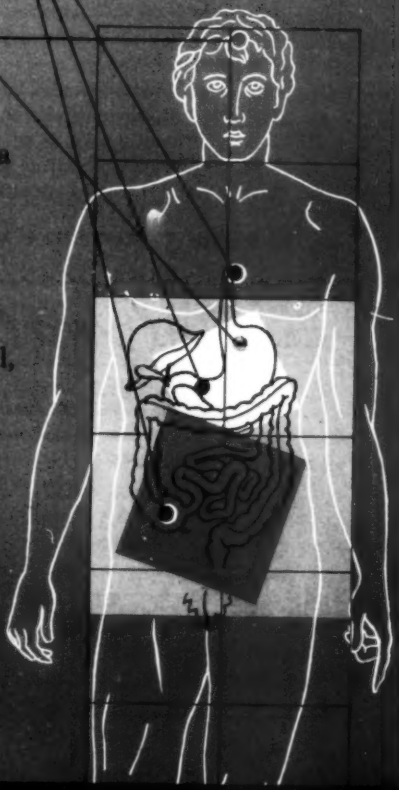
matropine *methyl*bromide.



WARK 1, N. J.

ing an appendicitis case to the hospital, according to Miller, the physician usually knows whether any tests are positive and what the blood counts are. So "when the patient receives a [hospital] bill to which $12.50 to $25 has been added for routine laboratory work . . . he immediately blames the physician."

Swatting Ghost Surgeons Stirs Up G.P. Hornets

Would keeping G.P.'s out of the operating room help cure "ghost surgery"? So it may have seemed last spring to Dr. Harold F. Bishop, chairman of the Westchester County (N.Y.) medical society's malpractice committee.

In a form letter to all chiefs of surgery in local hospitals, Dr. Bishop expressed his "hope that you may be in a position to discourage [ghost surgery] within your hospital." He cited one institution that had stamped out the practice by ruling that "no G.P. is allowed 'to assist' at an operation and that all post-operative care is restricted to the surgeon."

But within two days, reaction to the letter necessitated a hasty follow-up: "Apparently several chiefs of surgery . . . thought our letter . . . implied we had evidence of the existence of 'ghost surgery' in their hospitals. As a matter of fact, we have no evidence of this undesirable practice anywhere in Westchester County . . . Please accept our apology . . ."

Some really explosive opposition came, later, from the local chapter of the American Academy of General Practice. Its resolution denouncing Dr. Bishop's letter calls it "an unwarranted slap at the great body of general practitioners." A ban against G.P.-surgeon collaboration, it maintains, would "lead to a more disturbed physician-patient relationship" than "ghost surgery" produces.

"We are not in favor of sin," writes Dr. George J. Newman, secretary of the A.A.G.P. chapter. "Therefore, we must wholeheartedly endorse Dr. Bishop's stand against 'ghost surgery' . . . But we are not in accord with his solution of disciplining the ghost surgeon by punishing the G.P. Where the evil-doers are known, let them be punished by measures commensurate with *their own* wrongdoing."

How Squeezing 46 into 30 Gives Chair Sickness

That familiar squawk about too many medical meetings has been raised again—this time in Indianapolis. A quick check of four hospitals there has revealed forty-six meetings scheduled for a single month; and the Indianapolis Medical Society Bulletin comments wryly that "this is sixteen more meetings than there are days in the month."

Further arithmetic shows the prospect faced by any "Dr. Eagerbeaver" who tries to attend every meeting (allowing an hour for each): "The good doctor would spend forty-six hours a month in

meetings, or more than one solid work week."

The effect: "weaverbottom's disease," warns the bulletin. The remedy: fewer medical gatherings. Then Dr. Eagerbeaver could "stay home hunched up in a chair getting overstuffed bottom watching TV."

No Ivory-Tower Approach For These Future M.D.'s

A hardheaded band of family doctors are administering strong doses of general practice to some senior medical students this summer. Each preceptor physician has a student assigned to live in his home, haunt his office, tag along on hospital rounds, observe over his shoulder during house visits, nod through medical meetings, and even plunge out of bed for 3 A.M. emergency calls. Thus the preceptors are giving their novices a down-to-earth taste of the trials—and the challenge—of a family doctor's life.

This eleven-week preceptor program is being operated jointly by the University of Texas Medical Branch in Galveston and the Texas Academy of General Practice. Planned as an antidote for the cloistered atmosphere of classroom and big hospital, it gives senior medical students a chance to grapple with actual problems of medical practice, including the economic aspects.

"They [the students] should understand that a patient has an environment, a family, and a limit to his income—and that all these things

Convalescence calls for High Protein and Knox Gelatine

Convalescence is associated with protein loss of serious magnitude, yet little is known of the fundamental nature of the loss.[1] Less of nitrogen cannot be prevented, however, nitrogen balance can be maintained, wound healing enhanced, and convalescence shortened, by a high protein diet.[2]

Otherwise the patient uses his own "available" nitrogen stores to accomplish the healing defect.[3]

The patient "is better off before his nitrogen stores have been wasted than after. Surgeons have long noted that chronically debilitated patients are poor operative risks."[1] Decubitus ulcers heal quickly in heavily protein-fed patients.[4]

These facts are clear, as is also the fact that Knox Gelatine, which is pure protein, offers a useful method of supplementing the ordinary dietary protein.

Knox Gelatine is easy to digest, while its supplementary dietary nitrogen will furnish protein without other substances, especially salts of potassium which are retained during convalescence; without excess fat and carbohydrate, which are not needed especially; and without a food volume which may interfere with intake.

1. Howard, J. E. Protein Metabolism During Convalescence After Trauma. Arch. Surg. 50:166, 1945.
2. Co Tui, Minutes of the Conference on Metabolism Aspects of Convalescence Including Bone and Wound Healing. Josiah Macy, Jr. Foundation, Fifth Meeting Oct. 8-9, p. 57, 1943.
3. Whipple, G. H. and Madden, S. C. Hemoglobin, Plasma Protein and Cell Protein: Their Interchange and Construction in Emergencies. Medicine 23:215, 1944.
4. Mulholland, J. H., Co Tui, Wright, A. M., Vinci, V., and Skaficroft, B. Protein Metabolism and Bed Sores. Am. Surg. 118:1015, 1943.

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have an impact on his health problems," says Dr. D. Bailey Calvin, dean of the medical branch.

Most students prepare for their profession under circumstances that are too ideal, he believes. "They see patients in big charity hospitals where all kinds of laboratories, equipment, and drugs are handy and available without regard to cost. We know that medicine is seldom practiced under such ideal conditions. Such facilities aren't generally available, and patients couldn't afford them if they were."

So the preceptors are deliberately handing out some rugged assignments, following Calvin's directions not to get soft-hearted: "If you've kept up all night, keep your student right at your side. He's going to be a doctor in a year or two, and he's got to know what it's like . . . Put across the idea that practicing medicine is not an 8-to-5 business."

They're also initiating the boys into a doctor's responsibility to community life. At the request of Dr. V. D. Goodall, president of the Texas Academy of General Practice, they're dragging students along to club luncheons and church and political gatherings.

Groups Warned Against Soliciting Patients

Since it's unethical for individual physicians to solicit patients, it's equally so for medical groups, according to the New York County medical society.

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ciples of professional conduct, the society warns its members that a doctor may "take part in any action as a member of a group which he is not permitted ethically to do as an individual." Furthermore, it states, each member will be held answerable for any unethical conduct of his group or its authorized agents.

The chief categories in which the amplified ruling applies:

¶ Publicity stories concerning specific groups shall not be released to the lay press.

¶ Lettering on signs may not be more than three inches high.

¶ Announcements about the formation of a group, about changes in membership, or about a new location may be distributed only to bona fide patients and to the profession. They may be published only in medical journals or similar publications.

Says Folks Don't Snap Up Catastrophic Coverage

Insurance covering medical costs of catastrophic illness isn't being snapped up, as might have been expected, at first glance. This has been the experience of the Prudential Insurance Company in the year since its group major-medical-expense plan went on the market, according to Assistant Actuary Alan M. Thaler.

"It is difficult to measure how much the slowness in selling has been due to wage stabilization control," he comments. Regulations keep employers from sharing the expense of this insurance with their

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employes; and many employes, he adds, apparently consider it beyond their means.

This fact, says Thaler, is pointed up in an analysis of catastrophic coverage enrollment in one typical large corporation:

Salary Bracket	Employe Enrollment
$7,000 or more ..	100 per cent
$6,000-$7,000 ..	90 per cent
$5,000-$6,000 ..	78 per cent
Less than $5,000 .	45 per cent

Potential buyers, observes the Prudential actuary, thaw most readily when faced with this argument: "If you think you can't afford catastrophic insurance coverage, then how will you afford the medical bills it insures against?"

Charges Flood of Tycoons Inundates V.A. Hospitals

More evidence that V.A. medicine is out of bounds comes from an indignant St. Louis physician. "In this city and . . . others," charges Arthur R. Dalton, "there are many [with] adequate incomes that receive their medical care at veterans' facilities. Many physicians associated with these facilities have told me of executives of large business concerns receiving medical care for . . . conditions not related to their service in any way."

This constitutes a "pernicious, extravagant, and backdoor Federal medicine policy," as Dr. Dalton sees it.

In a letter to the Bulletin of the St. Louis Medical Society, he cites an apparently innocent news item

A NEW TREND IN INHALATION ANALGESIA

"TRILENE," self administered, relieves pain with minimum or no loss of consciousness

NEW YORK—In more than one million applications, "Trilene," a potent analgesic agent which can be self administered by adult or child, has demonstrated remarkable safety and effectiveness. Its use in surgery and obstetrics is marked by smooth, rapid induction of analgesia without loss of consciousness, or with only momentary unconsciousness. Inhalation, when an inhaler is employed for self administration, is automatically interrupted by any momentary lapse of consciousness. Recovery is swift, and devoid of nausea and vomiting. "Trilene" is nonexplosive, noninflammable in air and is well suited for use in homes, physicians' offices, first aid stations or hospitals.

Concerning its use in obstetrics, Gordon and Morton[1] state that the analgesia produced by "Trilene" is more profound and prolonged than that of any other presently available agent, including nitrous oxide. Smith[2] states that in "Trilene," "We have found the closest approach to the optimal analgesic agent for use in home obstetrics."

In minor surgery for both adult and child, Pickrell[3] lists numerous painful procedures often performed in the doctor's office where "Trilene" may be effectively employed. These include reduction of fractures, removal of painful dressings, incision and drainage of abscesses, and cystoscopies.

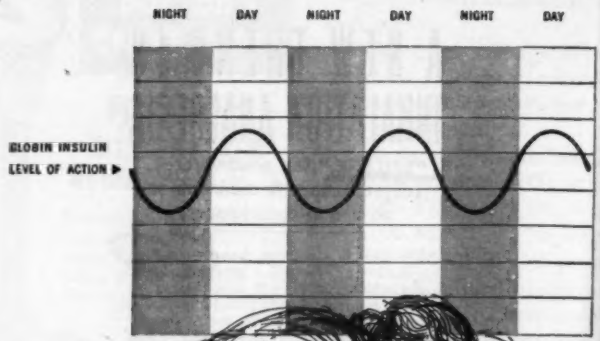
"Trilene" may also be used in standard anesthetic machines to insure complete analgesia while a light plane of anesthesia is maintained with other agents.

"Trilene," brand of highly purified trichlorethylene (Blue), is supplied in containers of 300 cc. Recommended for most convenient self administration is The "Duke" University Inhaler. Further information on "Trilene" or The "Duke" University Inhaler is available on request. Address inquiries to Ayerst, McKenna & Harrison Limited, 22 East 40th Street, New York 16, N. Y.

1. Gordon, R. A., and Morton, M. V.: Anesthesiology 12:680 (Nov.) 1951.

2. Smith, G.: GP 5:61 (Apr.) 1952.

3. Pickrell, K. L.; Stephen, C. R.; Broadbent, T. R.; Masters, F. W., and Georgiade, N. G.: In Press.



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For many diagnosed diabetics think of Globin Insulin because it possesses the highly desirable intermediate-timing of action; furthermore accurate measurement of doses is uncomplicated since it is a clear solution.

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celebrating admission of the 100,000th patient to the V.A. hospital at Jefferson Barracks in St. Louis. According to Dalton, the man, who was admitted for the treatment of a fractured arm, is a World War I veteran and a printer.

"After thirty years of being a civilian," the doctor comments, "a man who was once a soldier receives complete medical care at the taxpayers' expense for a fractured arm. This is . . . in no way . . . reproachful toward the veteran . . . Why shouldn't he avail himself of the privilege that others are obtaining also?"

Dalton's stand: "Being a veteran myself and also an American Legion member . . . I feel that I can speak freely . . . I don't believe that because I was once in one of our wars I'm entitled to complete medical coverage . . . all my life from our Government."

Can medical men help curb this tendency to deposit civilian ailments on V.A. doorsteps? Yes, says the doctor. He urges strong medical society support of a resolution to amend the Veterans Administration Act so that the V.A. may provide care only for service-connected disabilities.

Doctors Spurn Tax Aid For P.G. Tuition

Physicians prefer paying for postgraduate courses directly, through tuition, rather than indirectly, through tax support. So it would seem, at least, from the results of a

recent opinion poll of members of the Oregon State Medical Society.

For years, post-graduate lectures on obstetrics and pediatrics have been sponsored by the society and the state board of health. Federal funds have been financing them, funneled through the board's maternal and child health program. More recently, lectures on cancer have been underwritten by U.S. appropriations for cancer control. But 92 per cent of the doctors replying to the opinion poll say they're opposed to this use of Federal tax money. Use of state funds is decried by 86 per cent.

Of those indicating how they believe such courses *should* be financed, 79 per cent agree that physicians attending the lectures should pay their own way.

British Health Minister Finds Job Unhealthy

Britain's Conservative Minister of Health, Capt. Harry F. C. Crookshank, has been removed from office in Prime Minister Churchill's first Cabinet shake-up. And few Britishers are envying the lot of Crookshank's successor, who is now charged with the difficult task of remodeling Britain's "free-for-all" medical system.

Ostensible reason for Crookshank's dismissal: He's indispensable as Conservative leader in the House of Commons, where he must attend all sessions, day or night, as well as all party meetings on legislative strategy. But some say he has

...salts at sunrise...

"I clean the poisons out every day," he says—but he doesn't realize he is whipping a tired, irritated bowel.

Put this character on a treatment of Turicum. Explain to him it is not a one-shot cathartic but a restorative treatment that should be kept up for several days to help the bowel back to normal reflex peristalsis.

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had to bear an even heavier burden public resentment of newly required token payments for once-free appliances and prescriptions.

The new Minister, Iain Macleod, is regarded as one of the Conservatives' soundest experts on social problems. Also, he has shown a capacity for holding his own in Parliamentary debate with Opposition leader Aneurin Bevan, who is an acknowledged expert at needling Health Ministers about the National Health Service he himself launched.

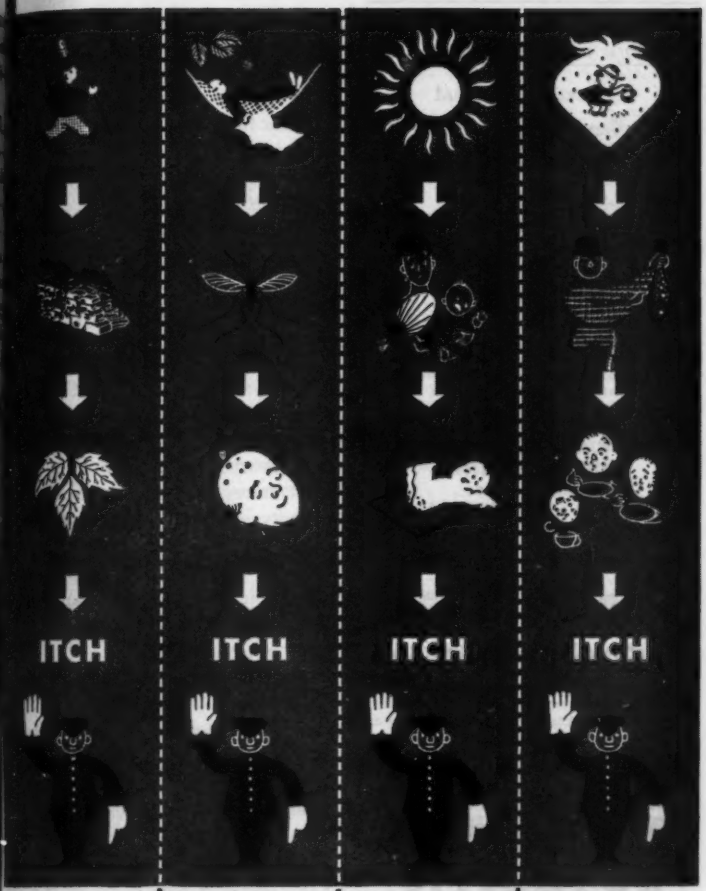
'Rejected Claims Alienate Blue Shield Subscribers'

"Does Blue Shield cover this, Doctor?" the patient asks. And too often a hurried physician responds by thoughtlessly signing a claim for benefits not provided by the contract. Then, if the claim is rejected, the resentful patient gets angry with Blue Shield—sometimes angry enough to cancel his membership.

About 300 claims vouched for by local doctors must be turned down every month, the Nebraska Medical Service reports. "Since each family membership represents 3.45 members and dependents," the 300 rejections could, it adds, result in cancellation of coverage for some 1,000 persons.

Few claims, says a spokesman for the plan, would be rejected if the physician only understood the terms of the contract. Blue Shield's simple recommendation: "Keep informed".

As a further reminder, the Nebraska Medical Service lists the



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"most commonly misunderstood" provisions of its contract:

¶ No benefits for office or home calls;

¶ Nor for X-rays, except when required for diagnosis of injury sustained in accidents;

¶ Nor for drugs, shots, medicines or their administration;

¶ Nor for bandaging or dressings.

What Is Legal Insanity? M.D.'s, Lawyers Disagree

The physician who shuns the witness chair during trials involving questions of sanity has good reason to be wary. Under existing laws in most states, medical testimony on insanity can easily degenerate into a contest of contradictory experts. Doctors testifying for the defense are often opposed by equally authoritative medical men testifying for the prosecution.

Result of such head-on collisions: "Most psychiatrists today . . . are unwilling to jeopardize their professional integrity by getting caught in a maze of legal questions their scientific knowledge does not qualify them to decide," reports Albert Deutsch, in a recent Woman's Home Companion article. Thus, he points out, the very best medical advice may be denied to the law courts.

"Equally unfortunate is the fact that some psychiatrists, sinister and reprehensible, sell their testimony to the highest bidder," says Deutsch. "A number of district attorneys and criminal lawyers maintain (unofficially, of course) a stable of such

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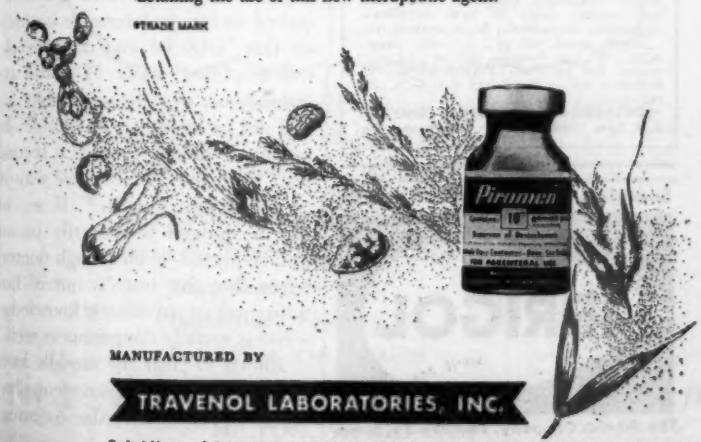

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psychiatric experts who can be counted on to testify as desired—for a fee."

The deplorable deadlock between reputable doctors and the criminal courts is traced by Deutsch to "the great gulf between mental disease and 'legal sanity' as defined by law." As an example, he cites the case of one Albert Fish, who pincushioned himself with nineteen sewing needles, was committed to several mental hospitals, and was eventually indicted for torturing, killing, and cooking children. "But a jury found him legally sane."

Until lawyers and doctors agree on what constitutes "legal insanity," Deutsch maintains, "we will continue to see murderers go scot free, guiltless men sent to their deaths, dangerously insane persons turned loose to repeat their destructive assaults on society."

So far, such agreement seems remote. In twenty-nine states, according to Deutsch, physicians *are required by law* to determine insanity on this "artificial and dangerously oversimplified" basis: "Did the accused know what he was doing... and did he know it was wrong?" In seventeen others, there is a second test: "Did the accused give way to an irresistible impulse?" If so, he can be judged temporarily insane and acquitted—even though doctors agree that this test "is out of line with modern psychiatric knowledge—and is socially dangerous as well."

Efforts to clear the muddle have been made by the American Psychiatric Association, the American

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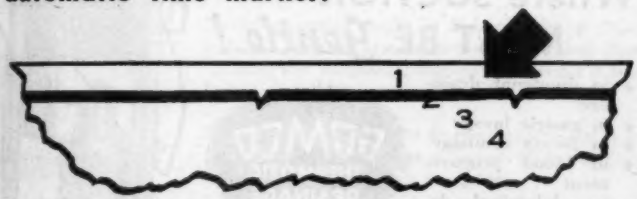

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Bar Association, and the A.M.A., says Deutsch, but with meager results. The American Bar Association has been urging state legislatures to adopt its model Expert Testimony Act, which doctors helped write. The act calls for panels of unbiased experts, appointed by the courts, to report impartially on the sanity of defendants. So far, however, only Vermont has adopted it.

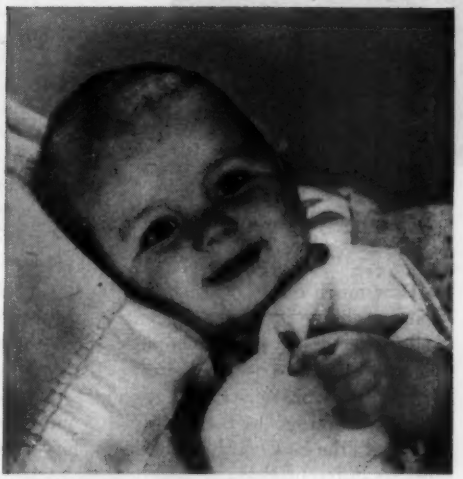
Massachusetts has had a comparable arrangement since 1921, Deutsch reports. Its Briggs Law provides that certain classes of defendants be automatically referred to psychiatrists for examination under state mental-health-department supervision. Dr. Winfred Overholser, American Psychiatric Association president, is quoted by Deutsch as believing that this system keeps Massachusetts courts free of squabbling medical witnesses. The catch: Low fees discourage thorough examinations, and the legal machinery is dangerously slow.

Reforms being tested elsewhere may, however, provide a better answer. Deutsch cites one such reform that doctors themselves have engineered: Since 1945, the Cincinnati Society of Neurology and Psychiatry has urged its members not to testify for either side in criminal trials. Instead, the society provides a panel of members willing to testify as impartial friends of the court. Adds Deutsch: "This system works effectively, with honor and benefit to all concerned. It should spread rapidly to other American localities."

Why

does she need

meat?



Because she's
allergic *to milk?*

Because she was
premature?

Because she's
convalescent?

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Memo from the Publisher

● How much do doctors across the country charge for house and office calls? How do these fees compare—by cities, by types of practice?

Do private physicians want Social Security coverage for themselves?

What's the hourly income of doctors in different fields of practice? How does this compare with the rates for skilled union workers?

These are just a few of the questions that MEDICAL ECONOMICS will soon be answering for you. Through the medium of our seventh quadrennial economic survey, nearly 9,000 private physicians have supplied us with the sort of personal data that some of them don't even tell their wives.

A balanced sample of their filled-in questionnaires is now being tabulated for us by Columbia University's Bureau of Applied Social Research. In the fall, we'll start publishing the results.

Meanwhile, here's a quick preview of what you can expect:

¶ Authoritative new facts about America's medical men: their political views, their cash contributions to charity, their assets, the extent of their participation in Blue Shield and similar health insurance pl

¶ Interesting comparisons w previous survey results in such ters as income, expenses, collecti and patient loads.

¶ Full-length economic profile different types of doctors—not the specialist and the G.P., but the young doctor, the big-city d tor, the group practitioner, the h income doctor, and others.

¶ Pictorial presentations thro out, accompanied by simple t highlights.

¶ Simultaneous publication o entire series in book form.

If you find valuable yardstick this forthcoming material (ther probably be more than a score articles), credit the individual d tors who took part in our surv Their cooperative spirit is typi by the M.D. who wrote: "My qu tionnaire got mailed in to you be I'd finished filling it out. Please s it back to me so that I can compl it."

Even though there was no w we could pick out his return fro the thousands already on hand, we're genuinely sorry we couldn't oblige. For he has performed a us ful service for the entire profess So has every other participant.

The real importance of their co tribution will become evident, w think, when you read the first of th survey articles this fall.

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No. 5: "Home Care of the Bedfast Patient."
No. 6: "Sick Room Precautions."